

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 1 0 5 5 0			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Opal Wright Abbe				2a. DATE OF DEATH MONTH DAY YEAR Apr. 20. 1980			
3. SEX Female				2b. HOUR 8:00 P.M.			
4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Oct. 17, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Indiana		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hosp.		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Nurse		12b. KIND OF BUSINESS OR INDUSTRY Medical					
13a. STATE Md.		13b. COUNTY Montg.		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Ludivico Wright		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dora Mary Cunningham		13e. STREET ADDRESS 100 Forest Ave.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-40-9910		17. INFORMANT ADDRESS Leslie M. Abbe Same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatous</u> 1749 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cancer of Breast</u> 1970 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) <u>1970</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>MALNUTRITION</u> <u>Phlebotomy</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1976
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <u>We</u> (this hospital) attended the deceased from <u>1-30</u> 19 <u>76</u> , to <u>4-20</u> 19 <u>80</u> , that <u>we</u> (we) last saw the deceased alive on <u>19</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above, <u>we</u> (we) (did not) view the body after death.							
22b. SIGNATURE <u>John S. Mason</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/21/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>J. S. SAIA (Mason)</u>				22e. ADDRESS <u>809 Vitas Mill Rd</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 4-24-80		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Fairfax Virginia	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY FUNERAL HOMES P/A				ADDRESS ROCKVILLE MD.		25a. DATE REC'D. BY REGISTRAR APR 28 1980	
				25b. REGISTRAR'S SIGNATURE <u>Dorothy McCreedy</u>			

ROBERT A. HUBBARD FUNERAL HOMES, INC.
METROPOLITAN CREMATORIUM
ALEXANDRIA, VIRGINIA

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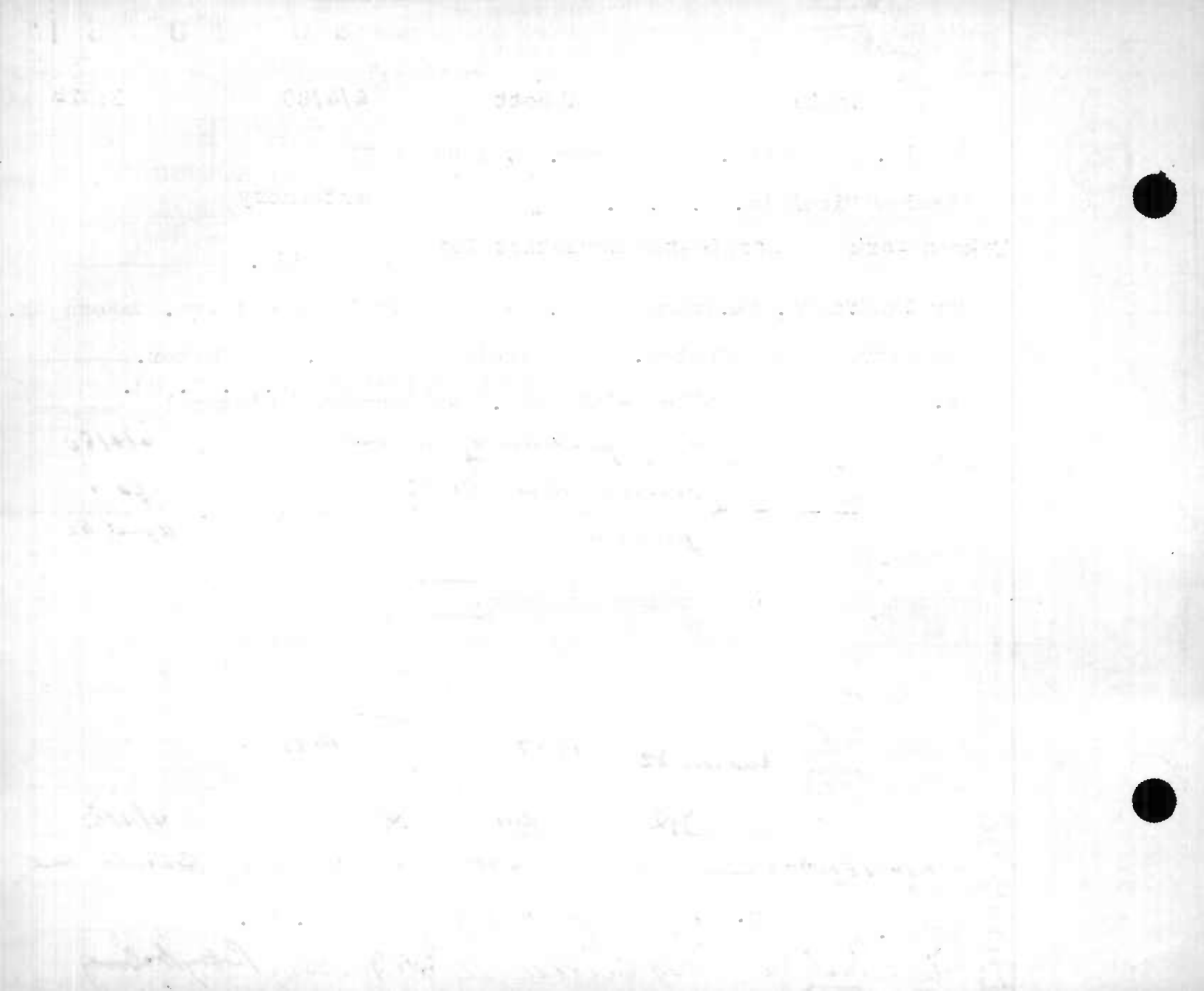
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 1 0 5 5 1	
1- FOR STATE REGISTRAR				REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) Annie Abbott			2a. DATE OF DEATH MONTH DAY YEAR 4/4/80		2b. HOUR 3:02 P M
3. SEX Female.	4. RACE White.	5. DATE OF BIRTH MONTH DAY YEAR Sept. 6, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Stanley Virginia. U. S. A.	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House Wife.		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Montg. Co. Takoma Park			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Mayberry Foster			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virgie M. Foster		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.		16b. SOCIAL SECURITY NO. 577-16-3896		17. INFORMANT ADDRESS 12204 Selfridge Rd. S. S. Md. Mrs. Nan Barrett (Sister)	
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest 438- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) cerebral thrombosis DUE TO, OR AS A CONSEQUENCE OF (c) pneumonia					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4/4/80 years april 80
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1977 , 19____, to 1980 , 19____, that (I) (we) lost saw the deceased alive on March 80 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE 				22c. DATE SIGNED 4/4/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) OSOOTH LEKATOS MD				22e. ADDRESS 7425 Arlington Rd, Bethesda Md	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Apr. 7, 1980		23c. NAME OF CEMETERY OR CREMATORY Beahm's Chapel	
23d. LOCATION CITY OR TOWN Luray. Va.		23e. COUNTY Luray		23f. STATE Va.	
24. FUNERAL DIRECTOR Arthur Valters		25. DATE REC'D. BY REGISTRAR APR 9 1980		26. REGISTRAR'S SIGNATURE 	



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 1 0 5 5 2
CERTIFICATE OF DEATH

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Wilhelmina E. Abercrombie <i>Wilhelmina ECKARDT Abercrombie</i>		7a. DATE OF DEATH MONTH DAY YEAR 4 16 80		7b. HOUR 6:50 A.M.	
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR 11-16-93		6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Minn.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10 CITY OR TOWN OF DEATH Silver Spring		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. STATE D.C.		13b. COUNTY Washington		13c. CITY OR TOWN Washington	
14 FATHER'S NAME FIRST MIDDLE LAST Oscar E. Eckardt		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Christina Wagner			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-62-8142		17 INFORMANT Son ADDRESS Jefferson H. Abercrombie Same as item 13	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 1830 DUE TO, OR AS A CONSEQUENCE OF (b) carcinomatous from ovary DUE TO, OR AS A CONSEQUENCE OF (c) 		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hr 6 wks
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (i) (this hospital) attended the deceased from 19 72 to APRIL 16 19 80 , that (ii) we last saw the deceased alive on April 14 19 80 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death)			
22b. SIGNATURE <i>Morton Shapiro</i>		DEGREE ATTENDING PHYSICIAN MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 4/16/80
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Morton Shapiro, M.D.		22e. ADDRESS 5225 Pooks Hill Road, Beth., Md. 20014	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 4/21/1980	23c. NAME OF CEMETERY OR CREMATORY Graceland Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Greenville S.C.
24 FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. ADDRESS 5130 Wisc. Ave., N.W. Wash., D.C.		25a. DATE REC'D. BY REGISTRAR APR 21 1980	25b. REGISTRAR'S SIGNATURE <i>Henry McCreedy</i>

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0		10553	
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH		2b. HOUR	
THEODORE R. ABLES				4 - 11 - 1980		3:15 A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Male		White		Aug. 19 1907		72 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
W. Va.		U.S.A.				MONTGOMERY COUNTY MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Rockville		SHADY GROVE ADVENTIST HOSPITAL		Painter		Montg. Co. Board of Educa.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. INSIDE CITY LIMITS?		13b. STREET ADDRESS	
13a. STATE 13b. COUNTY 13c. CITY OR TOWN				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		507 Beall Avenue	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
Charles C. Ables				Laura Jane Davisson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS	
No				296-01-7307A		Naomi Ables Same as 13c	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) Cardiovascular collapse 10 hrs							
DUE TO, OR AS A CONSEQUENCE OF (b) Saddle embolism of aorta 10-12 hrs							
DUE TO, OR AS A CONSEQUENCE OF (c) Bronchogenic carcinoma of bronchus 25-30 yrs							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 1st. Hemorrhage, 2nd. M.D.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION			
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (the hospital) attended the deceased from 1960 to 4/11/80, that (I) saw the deceased alive on 4/10/80, and that in my opinion death occurred on the date and hour and from the causes stated above, (I) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
William G. Hall				M.D.		4/14/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS		22f. MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/>	
William G. Hall				615 W. Montgomery Ave. Rockville, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		4/14/80		Mt. Olivet Cemetery		Frederick Frederick Md.	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Tyson Wheeler F.H. 1331 Rockville Pike Md.				APR 17 1980		[Signature]	

Lactuca officinalis 15-20 yrs
with small fruits
Caulis inermis. Lvs.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 0 1 0 5 5 4			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST James B. ADAMS.				2b. HOUR 11.05 P.M.			
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 8 1 01		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Railroad	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland 13c. COUNTY Montgomery 13d. CITY OR TOWN Silver Spr				13e. STREET ADDRESS 9907 Grayson Avenue,			
14. FATHER'S NAME FIRST MIDDLE LAST John Adams				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hanna Samuels			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. none 087-03-5578		17. INFORMANT (wife) ADDRESS Dorothy K. Adams-(same as 13e)	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Poorly Differentiated Carcinoma of the breast with metastasis							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Unknown
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
DUE TO, OR AS A CONSEQUENCE OF (b)							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Azotemia Small Stroke							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 63 to April 2, 19 80, that (I) (we) last saw the deceased alive on 4/2 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Alan R. Gair MD				DEGREE		22c. DATE SIGNED 4/3/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alan R. Gair MD				22e. ADDRESS 11700 Old Columbia Pike Silver Spring, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-5-1980		23c. NAME OF CEMETERY OR CREMATORY George Washington		23d. LOCATION CITY OR TOWN COUNTY STATE Adelphi Dr. Georges Md.	
24. PREPARED BY Warner E. Pumphrey, Inc. 8434 Ga. Ave., S.S. Md				25. REC'D. BY REGISTRAR		APR 7 1980	

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2025 COTTON LIVER

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO. 8010555				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MAURICE F. ADAMSON					2a. DATE OF DEATH MONTH DAY YEAR 4 30 80			2b. HOUR 5:45 P.M.	
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 11 4 1903		6 AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Guard		12b. KIND OF BUSINESS OR INDUSTRY Defense	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Md. Montg. Kensington					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4401 Colchester Dr.		
14 FATHER'S NAME FIRST MIDDLE LAST William W. Adamson					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary C. Davis				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-01-5924		17 INFORMANT Hannah R. Adamson			ADDRESS Same as 13		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pneumonia</u> 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Carcinoma of lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>4/17/80</u> , 19 <u>80</u> , to <u>4/30/80</u> , 19 <u>80</u> , that (I) (we) lost the deceased alive on <u>4/30/80</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Jeremy Beavers					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/30/80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jeremy Beavers					22e. ADDRESS 15400 Corn Ave Gaithersburg				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE May 5, 1980		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Md.		
24 FUNERAL DIRECTOR NAME Robert A. Pumphrey Homes, P.A.					25. DATE RECEIVED BY REGISTRAR MAY 8 1980				
25b. REGISTRAR'S SIGNATURE John J. McCreedy									

8/30/80
 10000 per the receipt
 8/30/80
 10000 per the receipt

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be dated for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 1 0 5 5 6			
1. FOR STATE REGISTRAR			CERTIFICATE OF DEATH								REG. NO.		
1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH DAY YEAR		2b. HOUR		
John E. Alahouzos						Apr. 30 1980			3:40 P.M.				
3 SEX			4 RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS	
Male			White		Mar. 25 1895			85 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Greece			U.S.A.						Montgomery County MD.				
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Silver Spring			Holy Cross Hospital			U.S. Steel Mill			Steel				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Md.			Mont.		Silver Spring			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		9604 Evergreen Street			
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST						FIRST MIDDLE LAST							
Emanuel Alahouzos						Irene Kouroumetis							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)						16b. SOCIAL SECURITY NO.			17. INFORMANT (Son) ADDRESS				
No						None			191-09-0085				
						John Alahouzos, Jr.			SAME AS #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
PART I: DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) <u>CHRONIC LUNG DISEASE</u>										20 YEARS			
496- DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
(b) DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
			HOUR A.M. MONTH DAY YEAR										
			P.M. 19										
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION							
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>3-10</u> 19 <u>80</u> , to <u>4-30</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>4-30</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE						DEGREE			22c. DATE SIGNED				
<u>A. OBOLER</u>						MD			4-30-80				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS							
A. OBOLER						106 IRVING ST. N.W. WASHINGTON, D.C.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION					
Burial			May 3, 1980		Gate of Heaven Cem.			Silver Spring Mont. Md.					
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Hines/Rinaldi						11800 New Hamp Ave., Sil. Spring, Md.			MAY 5 1980				
Funeral Home									F. J. McCreedy				

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TO HOSPITAL-ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 1 0 5 5 7			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) EUGENE H. ALLISON				2a. DATE OF DEATH MONTH DAY YEAR APR 12 '80		2b. HOUR 7:30 AM	
3 SEX MALE		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Dec. 4, 1899		6 AGE (IN YEARS LAST BIRTHDAY) 80 YRS. <input type="checkbox"/> MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD.	
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fairland Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Const. Inspector		12b. KIND OF BUSINESS OR INDUSTRY U.S. Navy	
13a. STATE Pennsylvania 13b. COUNTY Catawissa 13c. CITY OR TOWN Columbia				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS RD 2	
14. FATHER'S NAME FIRST MIDDLE LAST Horatio Allison				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hester O'Niel			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.		16b. SOCIAL SECURITY NO. 578-12-4167		17 INFORMANT ADDRESS 15303 Alan Dr. Ethel A. Starliper Laurel, Md. 20810			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebrovascular Accident DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Senility				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH HOURS YEARS YEARS			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4/4/80 to 4/12/80 , that (I) (we) saw the deceased alive on 4/4/80 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE THOS G. WARD DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/12/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOS G. WARD				22e. ADDRESS 6116 ROBIN WOOD RD, BETHESDA, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/15/80		23c. NAME OF CEMETERY OR CREMATORY Odd Fellows Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Danville, Montour, Pa.	
24. FUNERAL DIRECTOR FLECK LAUREL FUNERAL HOME, INC.				25a. DATE REC'D. BY REGISTRAR APR 15 1980		25b. REGISTRAR'S SIGNATURE Robert M. Brady	
7601 Sandy Spring Rd. Laurel, Md. 20810							

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE NO. 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		8 0 1 0 5 5 8	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE KNOWN OF DEATH	
FIRST MIDDLE LAST ALBERTO R. ALVAREZ		<input checked="" type="checkbox"/> MONTH DAY YEAR <input type="checkbox"/> 4 12 19 80	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)
male	Spanish	Aug. 7 1951	28 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH
CUBA	U.S.A.		Montgomery Co. MD.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Bethesda	Suburban Hospital	Truck Driver	Tire Co.
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?
Maryland	Montgomery	Rockville	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	13e. STREET ADDRESS	
FIRST MIDDLE LAST Patricio Alvarez	FIRST MIDDLE LAST Irene Romero Brito	210 Crabb Avenue	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS	
NO	213-58-8663	Helen E. Alvarez (same as 13e)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured heart</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?	
		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR <u>4:40</u> P.M. MONTH <u>4</u> DAY <u>12</u> YEAR <u>1980</u>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Market Tire Co.	21f. LOCATION STREET CITY OR TOWN COUNTY STATE 5481 Randolph Rd., Rockville, Montgomery Md.	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Ann M. Dixon</u>		TITLE (SPECIFY) <u>Assistant</u> MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) <u>Ann M. Dixon, M.D.</u>		DATE SIGNED <u>4/13/80</u>	
ADDRESS <u>111 Penn St.</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	4-16-80	Gate of Heaven Cem.	Silver Spring Montg. Md.
24. FUNERAL DIRECTOR		25a. DATE FILED BY REGISTRAR	
ROBERT A. PUMPHREY FUNERAL HOMES P/A		APR 22 1980	
		25b. REGISTRAR'S SIGNATURE <u>Anthony McCready</u>	

10-2-54

MEMORANDUM FOR THE RECORD

1951-52

X

U.S.A.

CUA

Truck Driver

213 Grand Avenue

Rockville

Maryland Montgomery

Delto

Alvarez

Alvarez

Alvarez

Alvarez

(Refer to Alvarez (case no 100))

813-25-0003

no

Silver Spring, Md.

State of Maryland

4-15-54

Delto

ROCKVILLE

ROCKY MOUNTAIN POWER CO.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8010559			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FLORENCE Elva ANDREWS				2a. DATE OF DEATH MONTH DAY YEAR 4-29-80		2b. HOUR 625P.M.	
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR 9 5 92		6 AGE (IN YEARS LAST BIRTHDAY) 87 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO. MD.	
10. CITY OR TOWN OF DEATH BETHESDA, MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST John Shackelford		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan Jane Jacobs		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. 577-84-7107		17 INFORMANT ADDRESS E. Linwood Andrews, same as #13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) cardio respiratory collapse 4140 DUE TO, OR AS A CONSEQUENCE OF (b) congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) atherosclerotic heart disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours 6 weeks years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the doctor) attended the deceased from 4/28 80 to 4/29 80 , that (I) (we) last saw the deceased alive on 4/28 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE John O. Allin M.D. DEGREE M.D.				22c. DATE SIGNED 4.29.80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John O. Allin M.D.				22e. ADDRESS 8218 Wisconsin Ave. Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/2/80		23c. NAME OF CEMETERY OR CREMATORY Columbia Gardens Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Virginia	
24 FUNERAL DIRECTOR Robert A. Pumphrey				25. DATE REC'D. BY REGISTRAR MAY 6 1980		25b. REGISTRAR'S SIGNATURE [Signature]	
25c. ADDRESS 7557 Wisconsin Ave., Bethesda, MD							

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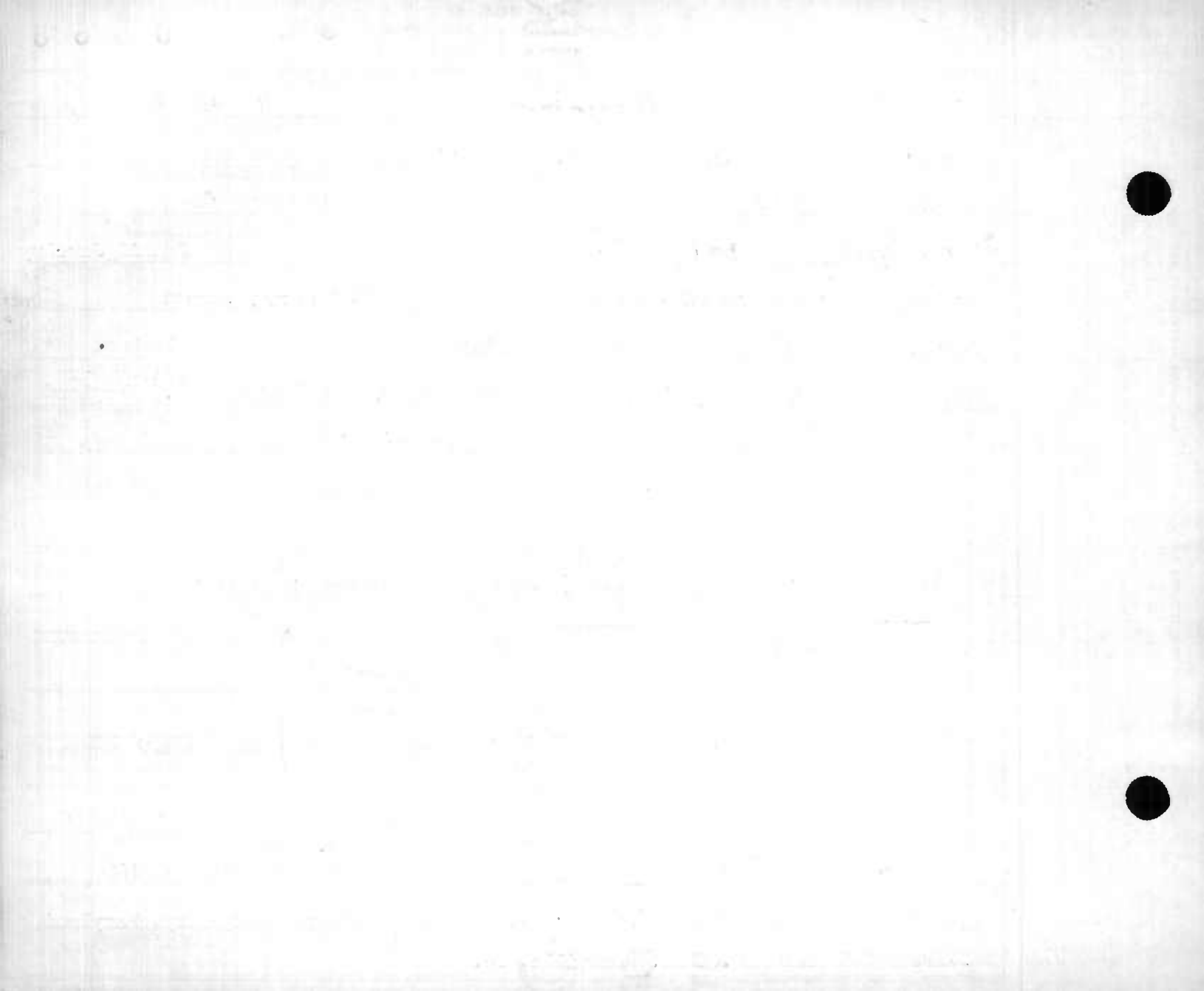
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8010560			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) ELI ARGINTAR				2a. DATE OF DEATH MONTH DAY YEAR 4 30 80		2b. HOUR 1:55 M	
3 SEX male		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Nov. 22, 1924		6 AGE (IN YEARS LAST BIRTHDAY) 55 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Mont. Co. MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager		12b. KIND OF BUSINESS OR INDUSTRY Retail Jewelry	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Sender ----- Argintar		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sallie ----- Fishman		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes (IF YES, GIVE WAR OR DATES) WWII			
16b. SOCIAL SECURITY NO 243-38-4054		17. INFORMANT ADDRESS Gaithersburg Annette Argintar, 9701 Fields Rd., Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOGENIC SHOCK 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) ACUTE MYOCARDIAL INFARCTION (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 HRS 24 HRS							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DIABETES MELLITUS							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. ----- 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4/19 1980 to 4/30 1980 , that (I) (we) lost saw the deceased alive on 4/30 1980 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.							
22b. SIGNATURE Arnold G. Levy M.D.		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 4-30-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARNOLD G. LEVY, MD		22e. ADDRESS 1106 SPRING ST. SILVER SPRING, MD. 20910					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-2-80		23c. NAME OF CEMETERY OR CREMATORY Judean Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Olney, Montgomery, Maryland	
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEM. CHAP., Rockville, Md.				25a. DATE AND PLACE OF REGISTRATION MAY 3 1980 25b. REGISTRAR'S SIGNATURE Marky McCready			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8010561 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CARL C. ARMSTRONG				2a. DATE OF DEATH MONTH DAY YEAR 04 20 80				2b. HOUR 11 28 AM
3 SEX Male		4 RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR 8-16-1914		6 AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASH. D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		
10 CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. 13b. COUNTY Montg. 13c. CITY OR TOWN Rockville				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 13 Welwyn Way		
14. FATHER'S NAME FIRST MIDDLE LAST Unknown				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 579-09-7911		17 INFORMANT ADDRESS Trene CURRY (GUARDIAN) Same AS #13				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 436- DUE TO, OR AS A CONSEQUENCE OF (b) CVA (c) DUE TO, OR AS A CONSEQUENCE OF other sclerotic APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) none								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 4/19/80 to 4/20/80, that (I) (we) last saw the deceased alive on 4/19/80 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE James L. Hooper MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/20/80		
23a. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES L. HOOPER MD				23b. ADDRESS 15 E DEER PARK DR GAITHERSBURG, MD 20760				
23c. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23d. DATE 4-25-80		23e. NAME OF CEMETERY OR CREMATORY Lincoln Park Cem.		23f. LOCATION CITY OR TOWN COUNTY STATE Rockville Montg. Md.		
24 FUNERAL DIRECTOR NAME GEORGE R. SPOONER				ADDRESS 2414 N. WASH. ST. ROCKVILLE, MD.		25a. DATE REC'D. BY REGISTRAR APR 21 1980		
25b. REGISTRAR'S SIGNATURE L. H. M. M. M.								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8010562 REG. NO.					
1 DECEASED NAME (TYPE OR PRINT) Linda K. Arnett			2a DATE OF DEATH MONTH DAY YEAR 4 5 80			2b HOUR 3:58 PM					
3 SEX female		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR 7 24 49		6 AGE (IN YEARS LAST BIRTHDAY) 30 YRS.		7 UNDER 1 YEAR MONTHS DAYS			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self Employed		12b KIND OF BUSINESS OR INDUSTRY Day Care			
13a STATE Maryland			13b COUNTY Montgomery		13c CITY OR TOWN Rockville		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 181 Talbott Street		
14 FATHER'S NAME FIRST MIDDLE LAST Leo A. DeWitt			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine M. Broughton			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b SOCIAL SECURITY NO. 251-52-8450	
17 INFORMANT Virginia C. Connolly			ADDRESS 35 Talbott St. Rockville, Md. 20852								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5770 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) Acute Pancreatitis 48 hours									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hours		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Systemic lupus erythematosus											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from above, (I) (we) did not view the body after death.											
22b SIGNATURE Paul T. Noone			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED 4/5/80		
22d PHYSICIAN'S NAME (TYPE OR PRINT) PAUL T. NOONE			22e ADDRESS 50 W. Edmonston Dr. Rockville, Md. 20852								
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 4/8/80		23c NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park			23d LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland			
24 FUNERAL DIRECTOR Tyson Wheeler			24b DATE REC'D. BY REGISTRAR APR 8 1980			24c REGISTRAR'S SIGNATURE Rickey McCreedy			24d REGISTRAR'S NAME Rickey McCreedy		



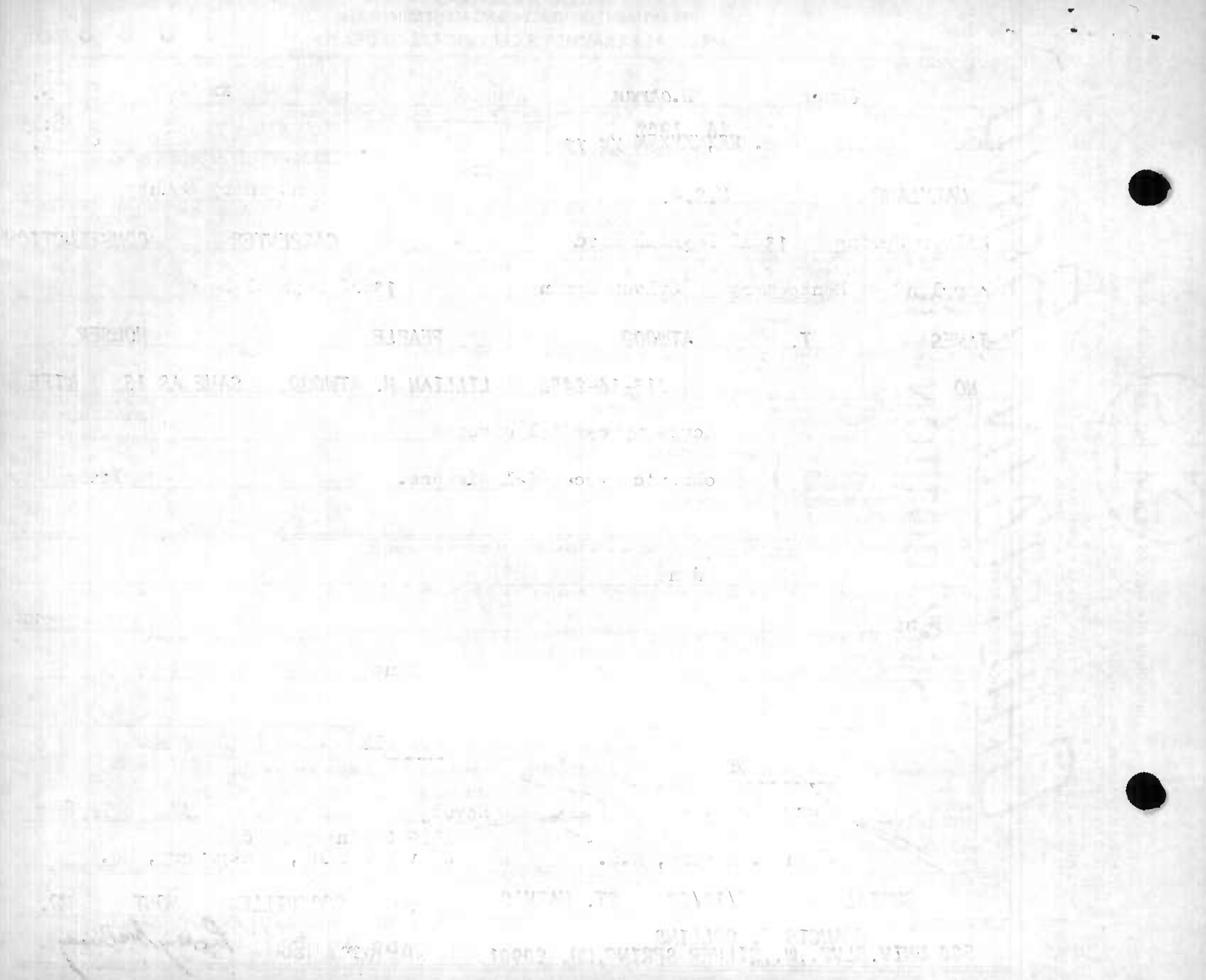
DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH-17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 10563	
1. DECEASED NAME (TYPE OR PRINT) James Norman Atwood						2a. DATE KNOWN OF DEATH ESTIMATED 4/9 19 80				2b. HOUR 11:00 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH 26 1902 Jun. 26 1902		6. AGE (IN YEARS) LAST BIRTHDAY 77 RS.		7c. DATE PRONOUNCED DEAD 4/10 19 80		2d. HOUR 8:15 A.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10. CITY OR TOWN OF DEATH Silver Spring				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 13612 Layhill Road				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CARPENTER				12b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION							
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 13612 Layhill Road			
14. FATHER'S NAME FIRST MIDDLE LAST JAMES T. ATWOOD				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST PEARLE HOUSER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 213-16-2456		17. INFORMANT LILLIAN M. ATWOOD				ADDRESS SAME AS 13 WIFE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4291 Acute myocardial disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) chronic myocardial disease. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). None											
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 				TITLE (SPECIFY) Deputy MEDICAL EXAMINER				DATE SIGNED 4/10/80			
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.				ADDRESS 1919 Seminary Road Silver Spring, Montgomery, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4/12/80		23c. NAME OF CEMETERY OR CREMATORY ST. MARY'S				23d. LOCATION CITY OR TOWN COUNTY STATE ROCKVILLE MONT MD.			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901						25a. DATE REC'D. BY REGISTRAR APR 17 1980		25b. REGISTRAR'S SIGNATURE 			



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

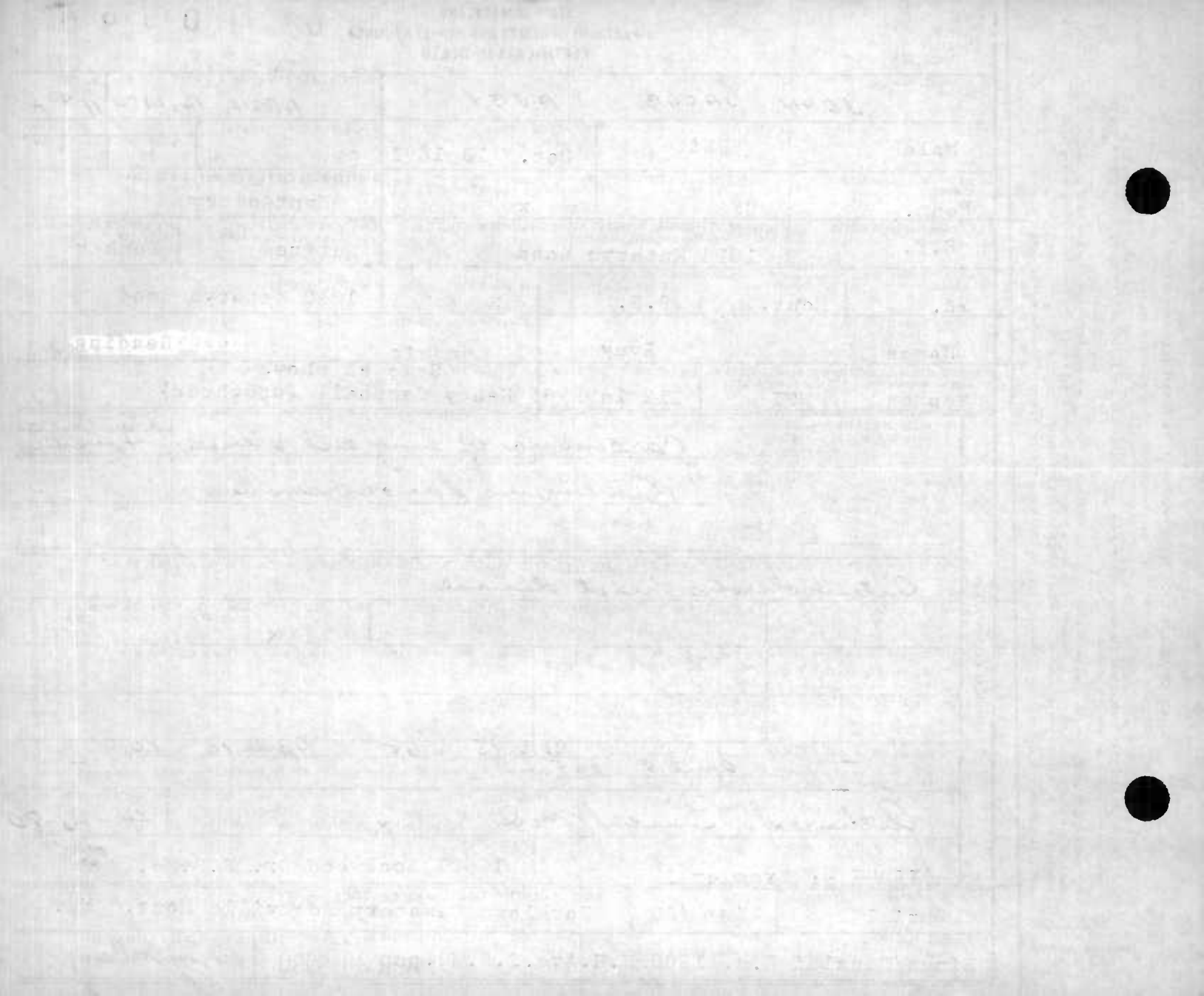
1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) JOHN JACOB AVEY			2a. DATE OF DEATH MONTH DAY YEAR APRIL 16, 1980			2b. HOUR 11 40 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 13 1891		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penn.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH S.S.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1012 Kathryn Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	
12b. KIND OF BUSINESS OR INDUSTRY Banker							
13a. STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN S.S.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 1012 Kathryn Road							
14. FATHER'S NAME FIRST MIDDLE LAST James Avey				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hedwig Hupfeld			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WWI 212 16 9905		17. INFORMANT Same as above Nancy Campbell (Daughter)			
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of lung and pleura</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Bronchiogenic adenocarcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic heart disease</u> Approximate interval between onset and death: <u>4 months</u> 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>Arteriosclerotic heart disease</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 15</u> , 19 <u>65</u> , to <u>April 16</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>April 5</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Arthur S. Bresler, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4-16-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Arthur S. Bresler				22e. ADDRESS 10881 Lockwood Dr. S.S.Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/19/80		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION Rockville Mont. Md.	
24. FUNERAL DIRECTOR NAME Hines/Rinaldi F.H.11800				25a. DATE REC'D. BY REGISTRAR APR 21 1980		25b. REGISTRAR'S SIGNATURE Dorothy McLeod	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-1234.

FOR STATE REGISTRAR				DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 1 0 5 6 5			
1- STATE REGISTRAR				CERTIFICATE OF DEATH				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) ^{FIRST} William ^{MIDDLE} H. ^{LAST} Bailey				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR			
WILLIAM H. BAILEY				4 20 80				11 P M			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7 UNDER 1 YEAR		8 UNDER 24 HRS	
Male		White		Feb. 2, 1894		86		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Texas		U.S.A.				MONTGOMERY Co., MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
BETHESDA		SUBURBAN Hospital				Photographer		Self-Employed			
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Matyland				Montgomery		Bethesda		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		7420 Westlake Terrace	
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST William Marcus Bailey				FIRST MIDDLE LAST Levenia Terry							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO		17 INFORMANT					
Yes				WW I		579-56-1438		8340 Resnick Lane Wilma B. Kennedy, Potomac, Maryland 20854			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIAC ARREST - VENTRICULAR FIBRILLATION</u>											
4039 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIO-SCLEROTIC HEART DISEASE.</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) <u>CHRONIC RENAL FAILURE - NEPHROSCLEROSIS</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <u>Large Left Cerebral Hematoma</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
				P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>4-7</u> 19 <u>80</u> , to <u>4-20</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>4-20</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
Roland Imperial MD				MD				4-21-80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
ROLAND IMPERIAL MD				4977 BATTERY LANE BETHESDA, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial				4/23/80		Ft. Lincoln Cemetery		Brentwood, Maryland			
24 FUNERAL DIRECTOR Joseph Gawler's Sons, Inc.						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
5130 Wisconsin Ave., NW, Washington, D.C. 20016						APR 24 1980		Therapy McCurdy			

Chronic Renal Failure - Nephrosclerosis
 Acute Renal Failure - Heart Disease
 Cardiac Arrest - Ventricular Fibrillation

Renal Impairment and
 Renal Failure
 14-51-80

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 0 1 0 5 6 6	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
Frances E Baldwin		April 2, 1980		1:00 P M	
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
Female	White	Nov. 13, 1898	81 YRS.	MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
Pennsylvania	USA			Montgomery County MD	
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION	12a USUAL OCCUPATION		12b KIND OF BUSINESS OR INDUSTRY	
Rockville	5309 Randolph Road	Resident Manager		Apartment	
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland		Montgomery	Rockville	YES <input type="checkbox"/> NO <input type="checkbox"/>	5309 Randolph Road
14 FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
Robert Felwell		Nellie Savage			
16a WAS DECEASED EVER IN U.S. ARMED FORCES?		16b SOCIAL SECURITY NO	17 INFORMANT ADDRESS		
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		579-01-7229	Mrs. Ruth Rowe (Daughter), same as #13		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:					Years
IMMEDIATE CAUSE (a) <u>Coronary artery disease</u>					
4149 DUE TO, OR AS A CONSEQUENCE OF					
(b) <u>Generalized atherosclerosis</u>					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
<u>Polymyalgia rheumatica, Diabetes mellitus</u>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d INJURY OCCURRED		21e PLACE OF INJURY		21f LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 19 <u>75</u> , to <u>4/2</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>3/26</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE		DEGREE		22c DATE SIGNED	
<u>Ernest Oser</u>				4/3/80	
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS			
Dr. Ernest Oser		10301 Georgia Avenue, Silver Spring, Maryland			
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION	
Burial		Apr. 5, 1980	Cedar Hill Cemetery	Sutland, P.G.Co., Maryland	
24 FUNERAL DIRECTOR NAME		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Hines/Rinaldi Funeral Home, Inc.		APR 7 1980		<u>Hines/Rinaldi</u>	
11800 New Hampshire Ave., Silver Spring, Md.					

1877

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR				REG. NO. 8010567					
1 DECEASED NAME (TYPE OR PRINT) LILLIAN A. BARON				2a DATE OF DEATH MONTH DAY YEAR April 6, 1980				2b HOUR 5:00 p.m.	
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 8, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10 CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5480 Wisconsin Avenue				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY -----	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Chevy Chase		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 5480 Wisconsin Avenue	
14 FATHER'S NAME FIRST MIDDLE LAST Barney Baer				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Chandler					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b SOCIAL SECURITY NO. 577-90-3980		17 INFORMANT ADDRESS Samuel Baron; 5480 Wisconsin Avenue; ChCh, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) myocardial infarction								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) chronic congestive heart failure									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) diabetes mellitus									
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 20, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from 4-2 19 79 to 4-6 19 80 we saw the deceased alive on 3-31 19 80 and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE James N. Brodsky MD				DEGREE For Dr. Luis Bentolita ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED 4-7-80	
22d PHYSICIAN'S NAME (TYPE OR PRINT) James Brodsky, MD				22e ADDRESS 4701 Willard Ave., Chevy Chase, Md.					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 4-9-80		23c NAME OF CEMETERY OR CREMATORY Wash. Hebrew Cong. Cem.			23d LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.		
24 FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels; 1170				ADDRESS Rockville, Md.		25a DATE RECD. BY REGISTRAR APR 11 1980		25b REGISTRAR'S SIGNATURE For Dr. Luis Bentolita	

U.S. DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D.C.

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WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH-16 25M
(VRA 15, 4) 1/79

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HELEN - BEBIE										2a. DATE OF DEATH MONTH DAY YEAR 4 4 80		2b. HOUR 330 P.M.					
3 SEX FEMALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 2 15 86		6 AGE (IN YEARS LAST BIRTHDAY) 94 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 72 HRS HOURS MIN.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Switzerland		7b. CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.											
10 CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY At home									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND										13b. COUNTY MONTGOMERY		13c. CITY OR TOWN CHEVY CHASE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 28 GRAFTON ST.	
14 FATHER'S NAME FIRST MIDDLE LAST Giovanni - Gilli					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha - Schmid												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 487-50-2262		17 INFORMANT ADDRESS Seattle, Wa. 98112 Yvonne Stoner (Daughter) 1855-East Shelby St.													
18 CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction (Beta Strip) 0380 DUE TO, OR AS A CONSEQUENCE OF (b) Systolic Hypertension (Beta Strip) DUE TO, OR AS A CONSEQUENCE OF (c) Massive lower L.V. hemorrhage PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that (I) (this hospital) attended the deceased from Mar 27 19 80 , to Apr 4 19 80 , that (I) (we) last saw the deceased alive on Apr 4 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.																	
22b. SIGNATURE Robert T. Thibadeau				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED Apr 4-80									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT T. THIBADEAU				22e. ADDRESS ROCKVILLE, MD. 20852													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 4-6-1980		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.											
24 FUNERAL DIRECTOR NAME J.Wm.Lee's Sons Co.				ADDRESS 300-4th St., NE, Wash., D.C.				25a. DATE REC'D. BY REGISTRAR APR 8 1980		25b. REGISTRAR'S SIGNATURE Robert T. Thibadeau							



U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535

TO : DIRECTOR, FBI (100-334310)
FROM : SAC, NEW YORK (100-100000) (P)
SUBJECT: [Illegible]

RE: [Illegible]
[Illegible]

DATE: [Illegible]
[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

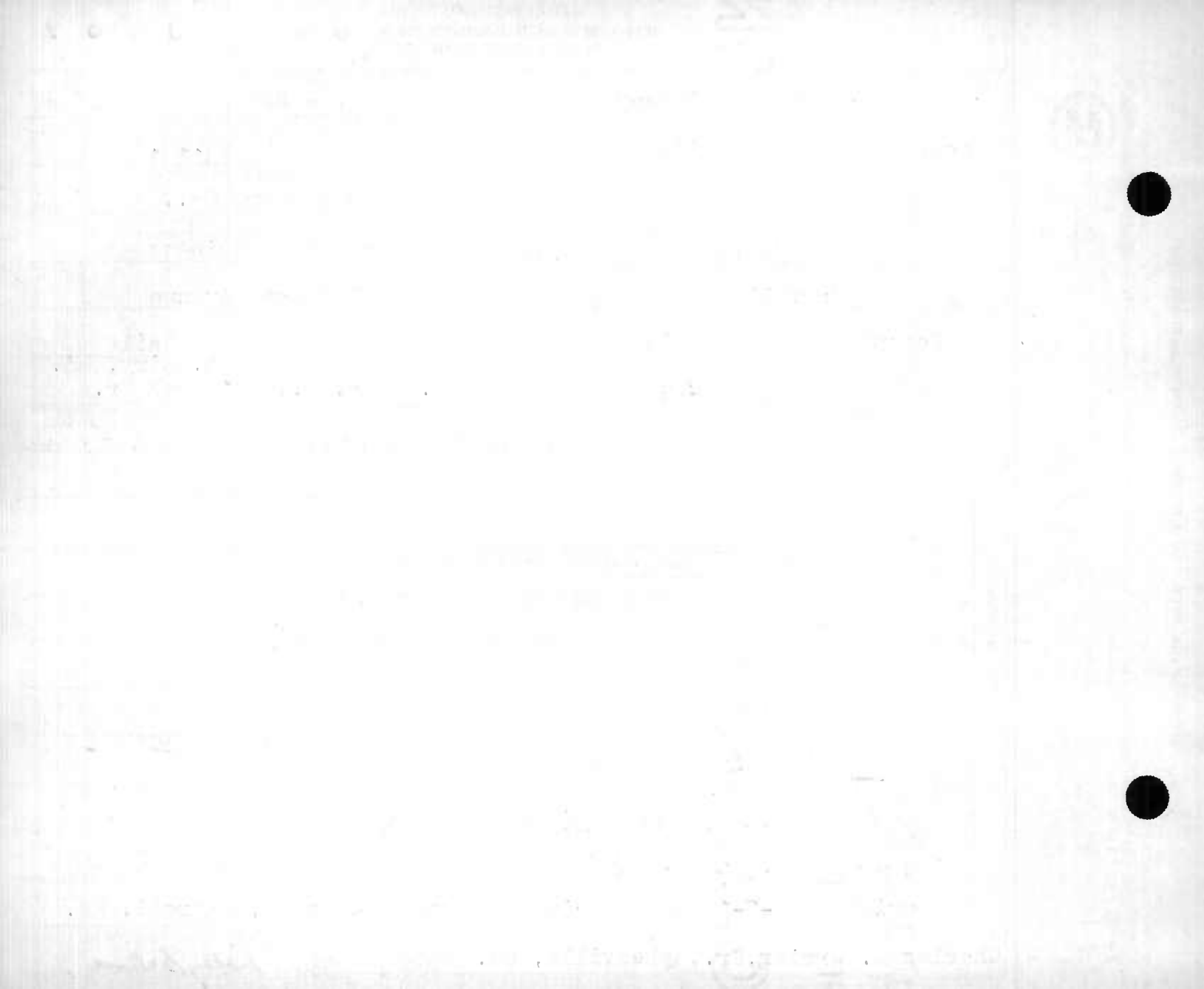
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 1 0 5 6 9	
1. FOR STATE REGISTRAR			REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
MARIE			Lindsay BECK			4-4-80			2:00 A.M.		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.	
Female		White		4 28 1891		88 YRS.		11 16			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
MARYLAND		USA				Montgomery Co., MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Rockville, Md.		Potomac Valley Nsg Home						Hatchery Business			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
			Md.			Carroll			Mt. Airy		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS		
Joseph Lindsay			Clara Baile						205 Park Avenue		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No			217 12 1868			Herman S. Beck, Jr.			Mt. Airy, Md. 501 Beck Dr.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4409 Generalized Arteriosclerosis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11+ years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
DUE TO, OR AS A CONSEQUENCE OF (b)											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
			P.M. 19								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (the hospital) attended the deceased from 19 69 to 4/4 19 80, that (we) lost saw the deceased alive on 3/25 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did not) view the body after death.											
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
James W. Egan			M.D.						4/4/80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS								
James W. EGAN			5413 Cedar Ln. - Bethesda, Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY STATE		
Burial			4-7-1980		Messiah Lutheran		Berrett, Carroll, Md.				
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Charles W. Burrier, Jr., Sykesville, Md.						APR 7 1980		R. W. Burrier			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DHMH-16 25M
(VRA 15, 4) 1/79

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 0 1 0 5 7 0				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) SARAH				LAST Beck		2a DATE OF DEATH MONTH DAY YEAR APRIL 27-1980			2b HOUR 3:05 PM
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Dec. 20, 1907		6 AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		7 UNDER 1 YEAR MONTHS DAYS 8 UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Saleswoman		12b. KIND OF BUSINESS OR INDUSTRY Ladies Wear	
13a STATE Maryland				13b COUNTY Montgomery		13c CITY OR TOWN Rockville		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Nathan --- Sill				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Yetta --- Yelsky					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b SOCIAL SECURITY NO 216-38-5495A		17 INFORMANT ADDRESS Wisc. Arthur Beck; 62 Yankee Peddler Path; Madison,			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Rupture								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr.	
410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Anteroseptal myocardial Infarction								5-6 hr.	
(c) Coronary Sclerosis								5 years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes Mellitus; Essential Hypertension.									
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from Sept. 15 , 19 71 , to 4/27 , 19 80 , that (I) (we) last saw the deceased alive on 4/14 , 19 80 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Max G. Sherer M.D. DEGREE MD						22c DATE SIGNED 4/27/80			
22d PHYSICIAN'S NAME (TYPE OR PRINT) Max G. SHERER M.D.						22e ADDRESS 800 Pershing Dr. Silver Spring, Md 20910			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b DATE 4-29-1980		23c NAME OF CEMETERY OR CREMATORY Nat'l. Memorial Park		23d LOCATION CITY OR TOWN COUNTY STATE Falls Church, Virginia	
24 FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels; ADDRESS 1170 Rockville Pike						25a DATE REC'D BY REGISTRAR APR 30 1980		25b REGISTRAR'S SIGNATURE [Signature]	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 1 0 5 7 1			
1 - FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
I. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
FIRST MIDDLE LAST				MONTH DAY YEAR			
Richard C. BEK				April 16 1980			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Male		Caucasian		MONTH DAY YEAR Nov. 2 1917		62 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Nebraska		USA				Montgomery MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda		National Naval Medical Center		U. S. Army			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. INSIDE CITY LIMITS?			
13a. STATE 13b. COUNTY 13c. CITY OR TOWN				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
Maryland Montgomery Silver Spring				14001 Burning Bush Lane			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST				FIRST MIDDLE LAST			
Otto Paul Bek				Minna Marie Eichhoff			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO			
Yes				1941-67 526 60 3292			
17. INFORMANT				ADDRESS			
Frances L. Bek				See item 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART 1. DEATH WAS CAUSED BY							
IMMEDIATE CAUSE (a) <u>SEPTIC SHOCK</u>							
1629 DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							
(b) <u>PNEUMONIA</u>							
(c) <u>ADENOCARCINOMA OF LUNG</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>March</u> , 19 <u>79</u> , to <u>Apr. 16</u> , 19 <u>80</u> , that (I) (we) lost <u>above</u> , <u>Apr. 16</u> , 19 <u>80</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above, <u>I</u> (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
<u>J.K. O'DONNELL</u>				MD		Apr. 16, 1980	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
J.K. O'DONNELL				National Naval Medical Center, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		Apr. 18, 1980		Arlington National		Arlington Va.	
24. FUNERAL DIRECTOR NAME				25a. DATE RECD. BY REGISTRAR			
W. W. Chambers Co.				APR 21 1980			
ADDRESS				25b. REGISTRAR'S SIGNATURE			
Silver Spring, Md.				<u>Robert McCreedy</u>			

27th Dec

1901

1902

J. R. O'Donnell

1903

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR			8 0 1 0 5 7 2				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) <i>William H. Bell, Jr.</i>			2a DATE OF DEATH MONTH DAY YEAR <i>4 29 80</i>			2b HOUR <i>4 AM</i>				
3 SEX <i>male</i>		4 RACE <i>Black</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>5 21 08</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>71</i> YRS		7 IF UNDER 1 YEAR MONTHS DAYS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>WASH. D.C.</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery Co.</i> MD.				
10 CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Suburban Hospital</i>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>CARPENTER</i>		12b KIND OF BUSINESS OR INDUSTRY		
13a STATE <i>Maryland</i>			13b COUNTY <i>Mont.</i>		13c CITY OR TOWN <i>Wheaton</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <i>1230 Urens Mill Road</i>	
14 FATHER'S NAME FIRST MIDDLE LAST <i>William H. BELL, SR.</i>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>OCTAVIA JENKINS</i>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>WW II</i>		17 INFORMANT ADDRESS <i>Sister 1921 6th St. N.W.</i>		<i>WASH. D.C.</i>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hepatic Failure</i> 2773 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cholangiolos of liver</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Systemic Angiolos</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 hrs</i> <i>6 yrs</i> <i>6 yrs</i>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Hypertension</i>										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <i>4/23/80</i> 19 <i>4/29/80</i> 19, that (I) (we) lost saw the deceased alive on <i>4/23/80</i> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE <i>Jeremy Cooke</i>			DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <i>4/29/80</i>		
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>Jeremy Cooke MD</i>			22e ADDRESS <i>10900 Conn Ave Kensington</i>							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>			23b DATE <i>5-2-80</i>		23c NAME OF CEMETERY OR CREMATORY <i>Good Hope Cem.</i>		23d LOCATION CITY OR TOWN COUNTY STATE <i>SILVER SPRING Montg Md.</i>			
24 FUNERAL DIRECTOR NAME <i>George R. Snowden</i>			24b ADDRESS <i>246 N. WASH. ST. Rockville, MD 20850</i>		25a DAY BY REGISTRAR <i>MAY 5 1980</i>		25b REGISTRAR'S SIGNATURE <i>[Signature]</i>			



[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Ruth</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>Apr. 15 1980</i>			2b. HOUR <i>3⁴⁵ PM</i>							
3 SEX <i>Female</i>		4 RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>1887</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>93</i> YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Russia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>Russia</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.							
10. CITY OR TOWN OF DEATH <i>Rockville</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Hebrew Home of Greater Washington</i>				12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12a. KIND OF BUSINESS OR INDUSTRY <i>-----</i>					
13a. STATE <i>D.C.</i>			13b. COUNTY <i>-----</i>			13c. CITY OR TOWN <i>Washington</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
14. FATHER'S NAME FIRST MIDDLE LAST <i>Boruch --- Finkelstein</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Ethel --- (unknown)</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i>				16b. SOCIAL SECURITY NO. <i>579-60-6599</i>			
17. INFORMANT ADDRESS <i>Harry Berger; 2800 Quebec St. NW, Wash, DC</i>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>486-</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Severe Organic Brain Syndrome</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION <i>5/75</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Gastroctomy</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i> P.M.			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>4/5 1980</i> to <i>4/5 1980</i> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <i>4/5</i> 19 <i>80</i> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did <input type="checkbox"/> did not view the body after death.													
22b. SIGNATURE <i>Marsha Wallace MD</i>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <i>4/5/80</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>MARSHA T. WALLACE MD</i>			22e. ADDRESS <i>6121 Montrose Rd</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>4-8-1980</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Judean Memorial Gardens</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>Norbeck, Montg., Md.</i>					
24. FUNERAL DIRECTOR NAME <i>Danzansky-Goldberg Chapels, 1170 Rockville Pike</i>			ADDRESS <i>Rockville, Md.</i>			25a. DATE REC'D. BY REGISTRAR <i>APR 11 1980</i>		25b. REGISTRAR'S SIGNATURE <i>Henry McCreary</i>					

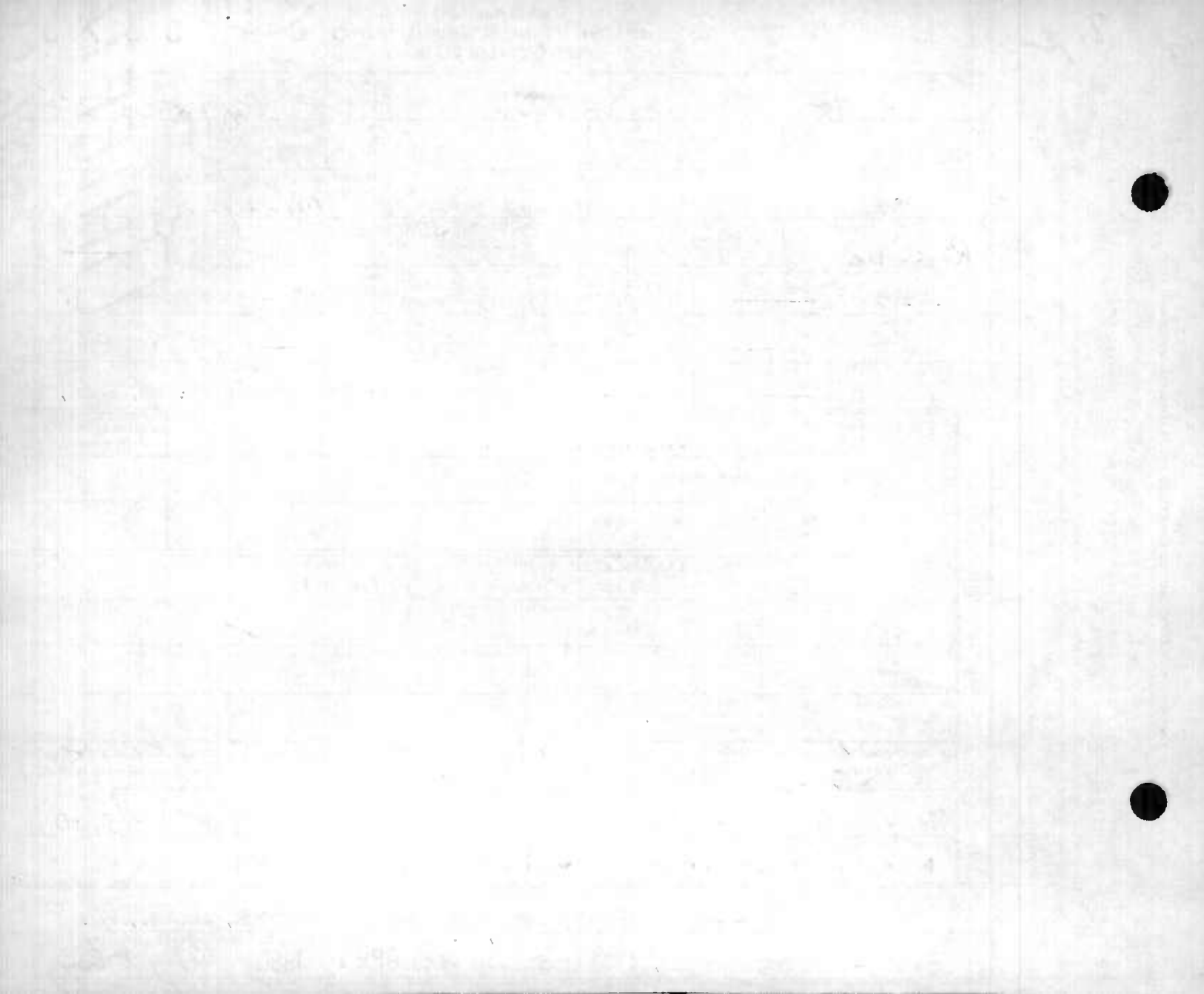
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove color paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY BERMAN			2a DATE OF DEATH MONTH DAY YEAR APRIL 3 80			2b HOUR 8 45 AM	
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR DEC. 12, 1888		6 AGE (IN YEARS LAST BIRTHDAY) 93	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY	
10 CITY OR TOWN OF DEATH ROCKVILLE		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION HEBREW HOME OF GREATER WASHINGTON		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b KIND OF BUSINESS OR INDUSTRY OWN HOME	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d STREET ADDRESS 1209 BURTON STREET,	
14 FATHER'S NAME FIRST MIDDLE LAST ABRAHAM BEERMAN		15 MOTHER'S MAIDEN NAME FIRST MIDDLE SARAH RACHMAN		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			
16b SOCIAL SECURITY NO. 159-09-7219D		17 INFORMANT ADDRESS RAYMOND M. APPLEBAUM 1111 UNIVERSITY BLVD. SILVER SPRING, MD.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPTICEMIA 5070 DUE TO, OR AS A CONSEQUENCE OF (b) ASPIRATION PNEUMONITIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 DAYS							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) SENILE DEMENTIA							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from 2/18/69 , 19____, to 4/3/80 , 19____, that (I) (we) last saw the deceased alive on 4/3/80 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE D. D. PATEL		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 4/3/80	
22d PHYSICIAN'S NAME (TYPE OR PRINT) D. D. PATEL		22e ADDRESS 6121 MONTROSE RD. ROCKVILLE, MD.					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE 4/4/80		23c NAME OF CEMETERY OR CREMATORY B'NAT ISRAEL CONGREGATION CEMETERY		23d LOCATION CITY OR TOWN COUNTY STATE OXON HILL PR. GEORGES MD.	
24 FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME				25 DATE REC'D. BY REGISTRAR APR 7 1980			
25a ADDRESS 232 CARROLL STREET, N.W., WASHINGTON, D. C.				25b SIGNATURE [Signature]			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 1 0 5 7 5			
1- FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST Eleanor V. Besley		2a DATE OF DEATH MONTH DAY YEAR 4 18 80		2b HOUR 8 P.M.	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR June 11, 1914		6 AGE (IN YEARS LAST BIRTHDAY) 65 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Virginia Fairfax Springfield				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5750 Backlick Rd.	
14 FATHER'S NAME FIRST MIDDLE LAST Grover D. Lenthicum				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary V. Carlisle			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 577-30-0303		17 INFORMANT ADDRESS Fred Lenthicum, 19711 Waters Rd., Germantown, Md. 20767			
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive heart failure 496- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Respiratory failure (c) Chronic obstructive pulmonary disease DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hours 2 days years							
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) July 29, 1980		21f LOCATION STREET CITY OR TOWN COUNTY STATE 4/18 80			
22a I certify that (I) (the hospital) attended the deceased from 4/18/80 to 4/18/80, that (we) last saw the deceased alive on 4/18/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.)							
22b SIGNATURE JOS G. WARD MD				DEGREE MD		22c DATE SIGNED 4/19/80	
22d PHYSICIAN'S NAME (TYPE OR PRINT) JOS G. WARD				22e ADDRESS 6116 Rabinwood Bethesda, Md. 20814			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Apr. 22, 1980		23c NAME OF CEMETERY OR CREMATORY Fairfax		23d LOCATION CITY OR TOWN COUNTY STATE Fairfax, Fairfax, Virginia	
24 FUNERAL DIRECTOR NAME Olin L. Molesworth, Damascus, Md.				25a DATE RECD. BY REGISTRAR APR 22 1980		25b REGISTRAR'S SIGNATURE	

John L. Moleworth, Kansas, Mo.

Burial Apr. 22, 1980 Fairfax Virginia Fairfax, Virginia

no 577-30-0303 Fred Lanthicum, Germantown, Md. 20857

Grover D. Lanthicum Mary V. Carlisle

Virginia Fairfax Springfield x 5750 Mackinac Rd.

Housewife

Married

U.S.A.

x

June 11, 1974

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Female

White

Doctor

V.

1974

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8010576	
1. FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) Victor Emil Bieber, Sr.					2a. DATE OF DEATH MONTH DAY YEAR April 8, 1980				2b. HOUR 12:25p		
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR April 16, 1895		6 AGE (IN YEARS LAST BIRTHDAY) 84 YRS		7a. UNDER 1 YEAR MONTHS DAYS		7b. UNDER 24 HRS. HOURS MIN.	
7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D. C.		7d. CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fernwood House				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist		12b. KIND OF BUSINESS OR INDUSTRY Navy Dept.			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY Montg.		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST Henry Bieber					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Meininger						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 214-42-3127		17 INFORMANT 4921 E. Cumberland Ave. Victor E. Bieber, Jr., Chevy Chase, MD							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> <u>4039</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ursemia</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last: (c) <u>neuro sclerosis</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 minutes</u> <u>3 months</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>generalized arterio sclerosis</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (the hospital) attended the deceased from <u>Sept 4-8</u> , 19 <u>80</u> , to <u>4-8</u> , 19 <u>80</u> , that (I) <u>did</u> did not saw the deceased alive on above, (I) <u>did</u> did not view the body after death.											
22b. SIGNATURE <u>John F. Tauber</u>					DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>4-8-80</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John F. Tauber, M.D.					22e. ADDRESS 8218 Wisconsin Ave., Bethesda, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4-10-80		23c. NAME OF CEMETERY OR CREMATORY Parklawn Mem. Park			23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland			
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland					25a. DATE REC'D. BY REGISTRAR APR 15 1980		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

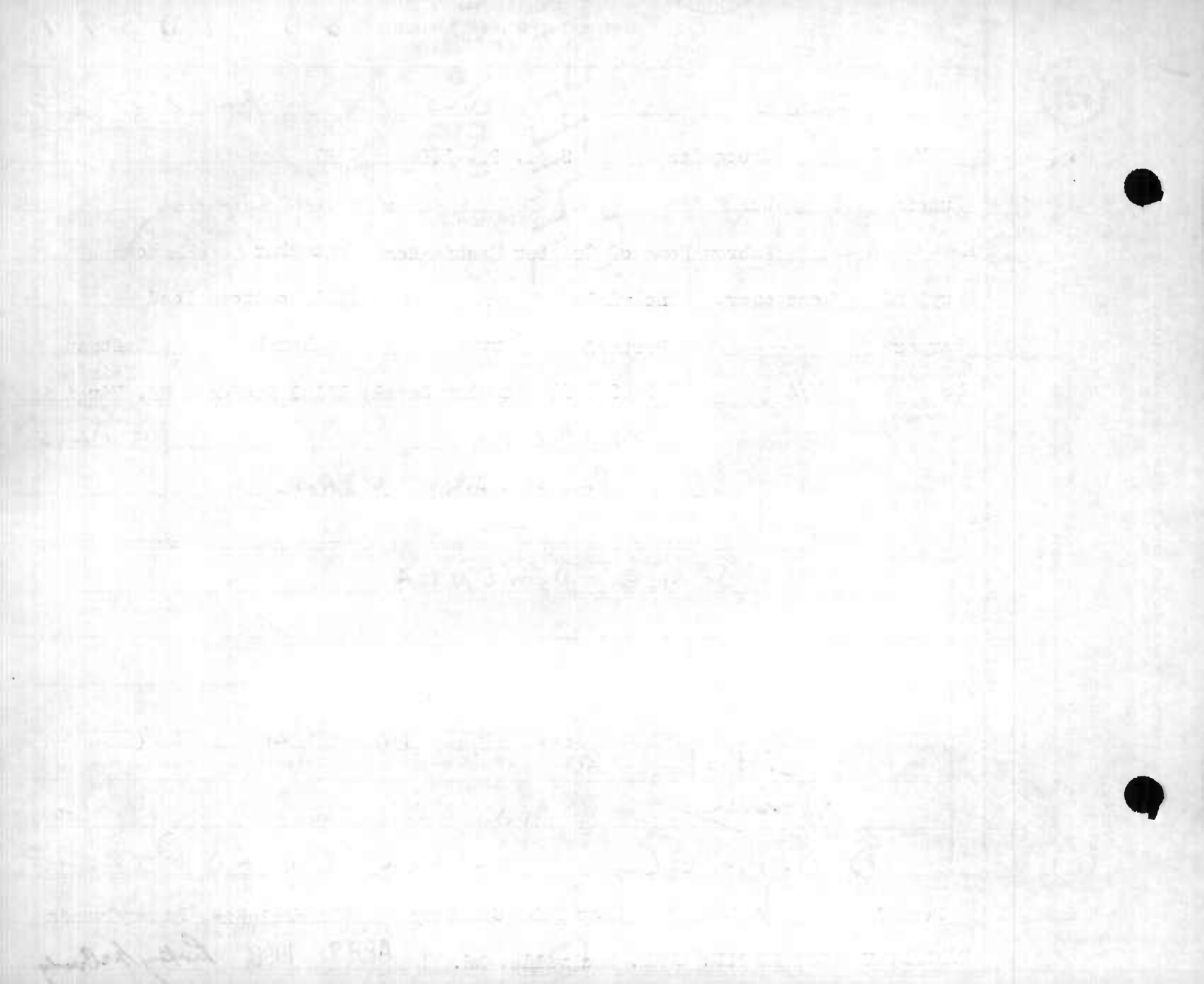
REG. NO.

1. FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Zeldow		FIRST		MIDDLE		LAST Bielouss		2a DATE OF DEATH MONTH DAY YEAR April 2 80				2b HOUR 7⁴⁵ PM	
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR Sept. 30, 1882				6 AGE (IN YEARS LAST BIRTHDAY) 97 YRS				IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10 CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hebrew Home of Greater Washington				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker				12b KIND OF BUSINESS OR INDUSTRY Home			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland				13b COUNTY Montgomery		13c CITY OR TOWN Rockville		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 6121 Montrose Road			
14 FATHER'S NAME FIRST MIDDLE LAST Bernard --- Portnoi				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fruma Deborah Zeitzev									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17 INFORMANT ADDRESS Fairfax, Virginia							
				18b SOCIAL SECURITY NO. 183-03-7054				17 INFORMANT ADDRESS Stanley Segal, 11103 Braddock Rd. Fairfax, Virginia					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PNEUMONIA												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 DAYS	
4809 } DUE TO, OR AS A CONSEQUENCE OF (b) PRESUMABLY VIRAL													
DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) SENILE DEMENTIA													
19a DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Sept. 19, 1960 to 4/2/80 , that (I) (we) last saw the deceased alive on 4/2/80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE D. D. Patel				DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 4/3/80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. D. PATEL				22e. ADDRESS 6121 MONTROSE RD. ROCKVILLE									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 4-4-80		23c. NAME OF CEMETERY OR CREMATORY Har Nebo Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Philadelphia, Pennsylvania			
24. FUNERAL DIRECTOR NAME ADDRESS DANZANSKY-GOLDBERG MEM. CHAP. Rockville, Md.				25a. DATE REC'D. BY REGISTRAR APR 7 1980				25b. REGISTRAR'S SIGNATURE Barbara McCreedy					

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. FOR STATE REGISTRAR			2a. DATE OF DEATH		7b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST <u>G.</u> MIDDLE <u>Steuart</u> LAST <u>Bingman</u> <u>G. STEUART BINGMAN</u>			MONTH DAY YEAR <u>APRIL 18 1980</u>		<u>4:15 P.M.</u>	
3 SEX <u>Male</u>	4 RACE <u>White</u>	5 DATE OF BIRTH MONTH DAY YEAR <u>March 6, 1896</u>	6 AGE (IN YEARS LAST BIRTHDAY) <u>84</u> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Penna.</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> MD.			
10 CITY OR TOWN OF DEATH <u>Takoma Park</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Sligo Gardens Nursing Home</u>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Ret.- Appraiser</u>	12b. KIND OF BUSINESS OR INDUSTRY <u>Fed. Hous. Adm.</u>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>Texas</u> 13b. COUNTY <u>Collin</u> 13c. CITY OR TOWN <u>Plano</u>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <u>1821 Rustic Drive</u>		
14. FATHER'S NAME FIRST MIDDLE LAST <u>Henry A. Bingman</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Margaret E. Wilson</u>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>578-07-5456</u>		17. INFORMANT ADDRESS <u>Helen Raye, Daughter, Same as # 13.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u> <u>4140</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Dehydration, Arteriosclerotic Heart Disease</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>3/18/80</u> to <u>4/18/80</u> , that (I) was lost saw the deceased alive on <u>4/18/80</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)						
22b. SIGNATURE <u>Antonio G. Uy</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>4/18/80</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ANTONIO G. UY</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
22e. ADDRESS <u>831 Vine Blvd E. S.E. Md</u>		<u>20703</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>4/21/80</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>		
23d. LOCATION CITY OR TOWN COUNTY STATE <u>Silver Spring, Maryland</u>						
24. FUNERAL DIRECTOR NAME <u>Jos. Gawler's Sons, Inc., Washington, D.C. 20016</u>		5130 Wis. Ave., N.W. ADDRESS		25a. DATE REC'D. BY REGISTRAR <u>APR 23 1980</u>		
25b. REGISTRAR'S SIGNATURE <u>Anthony M. Cready</u>						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH				2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)		3. SEX				4. RACE			
FIRST MIDDLE LAST		Male				Black			
William Blount		5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)			
MONTH DAY YEAR		Apr. 20, 1925				55 YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY	
Ga.		U.S.A.				Montgomery MD.		Supt. Co. Schools, Md. Gov't	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
TAKOMA PARK		WASHINGTON ADULTS 1752A				Supt. Co. Schools		Md. Gov't	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md.		P.G.		Beaver Hgts.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			
FIRST MIDDLE LAST		FIRST MIDDLE LAST				Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
Unknown		Lonella Reese				WW II			
16b. SOCIAL SECURITY NO.		17. INFORMANT				ADDRESS			
260-28-6221		Hermene Blount-Same as # 13 above							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>respiratory failure</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>myocardial infarction</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR									
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NON-WORK <input type="checkbox"/> AT HOME									
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)									
21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (1) (this hospital) attended the deceased from <u>3/24</u> 19 <u>80</u> to <u>4/25</u> 19 <u>80</u> that (1) (we) last saw the deceased on <u>4/25</u> 19 <u>80</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE DEGREE									
22c. DATE SIGNED									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)									
22e. ADDRESS									
LEWIS H. DENNIS, M.D.									
831 Univ. Blvd., Silver Spring, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)									
23b. DATE									
23c. NAME OF CEMETERY OR CREMATORY									
23d. LOCATION CITY OR TOWN COUNTY STATE									
Burial 4-29-80 Harmony Mem. Cem. Highland Park, Md.									
24. FUNERAL DIRECTOR NAME ADDRESS									
H. S. WASHINGTON & SONS 4125 BULLOUGH AVE. N.E.									
25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE									
MAY 1 1980									

Burial

4-29-80

Harmony Mem. Cem. Highland Park, Md.

831 Univ. Blvd., Silver Spring, Md.

Yes

WM II

260-28-6221 Berneice Elmont-Jane ne 13 above

Unknown

Lomaia

Reese

Ms.

F.C.

Beaver Hts. 1

1222 Beaver Hts. 1a.

Supt. Co. Schools, Md. Gov't

Da.

U.S.A.

White

Black

Apr. 20, 1922

22



FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

80 10580

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MAMIE Lee BREEDEN			2a. DATE OF DEATH MONTH DAY YEAR APR 16 '80			2b. HOUR MIN. 6:45 A			
3 SEX FEMALE		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR 12 1 1899		6. AGE (IN YEARS LAST BIRTHDAY) 80		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery			
10. CITY OR TOWN OF DEATH Kensington		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kensington Gardens Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 314 Edmonston Drive	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Pugh					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eliza Phillips				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 578 01 2949D			17. INFORMANT ADDRESS Lucille B. Hartley same as 13e			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrovascular Accident								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year		
436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis								years		
DUE TO, OR AS A CONSEQUENCE OF (c) Senility										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Senility			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE 6116 Robinwood Bethesda Md 20034				
22a. I certify that (I) (this hospital) attended the deceased from 4/8/80 to 4/16/80 , that (I) (we) lost saw the deceased alive on 4/8/80 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
27a. SIGNATURE Thos G. Ward						DEGREE MD		27b. DATE SIGNED 4/16/80		
27c. PHYSICIAN'S NAME (TYPE OR PRINT) Thos G. Ward						27d. ADDRESS 6116 Robinwood Bethesda Md 20034				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/19/80			23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park			23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland	
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. ADDRESS 1331 Rockville Pike Rockville, Md. 20852						25a. DATE REC'D. BY REGISTRAR APR 19 1980		25b. REGISTRAR'S SIGNATURE Anthony J. Brady		

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Julius		FIRST —		MIDDLE		LAST Brock		2a. DATE OF DEATH MONTH DAY YEAR 4-30-80		2b. HOUR 235 AM	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Dec. 12 1913			6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.				
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. CITY OR TOWN P.G. Boulevard Heights		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 1901 Clark Place				
14. FATHER'S NAME FIRST MIDDLE LAST Henry Brock				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lena Fields							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 578-12-5509		17. INFORMANT ADDRESS Wash., DC H St., N.E.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septic shock 1539 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) metastatic colon cancer DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 1979 to April 30, 1980 , that (I) (we) lost saw the deceased alive on April 29, 1980 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Dr. Haidan		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED 4/27/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR H AIDAN				22e. ADDRESS Balcon Rd Hyattsville, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/5/80		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, Maryland			
24. FUNERAL DIRECTOR NAME John V. Stewart, III				25a. DATE REG'D. BY REGISTRAR MAY 9 1980		25b. REGISTRAR'S SIGNATURE Anthony McCreedy					
Stewart Funeral Home-4001 Benning Rd., N.E.											

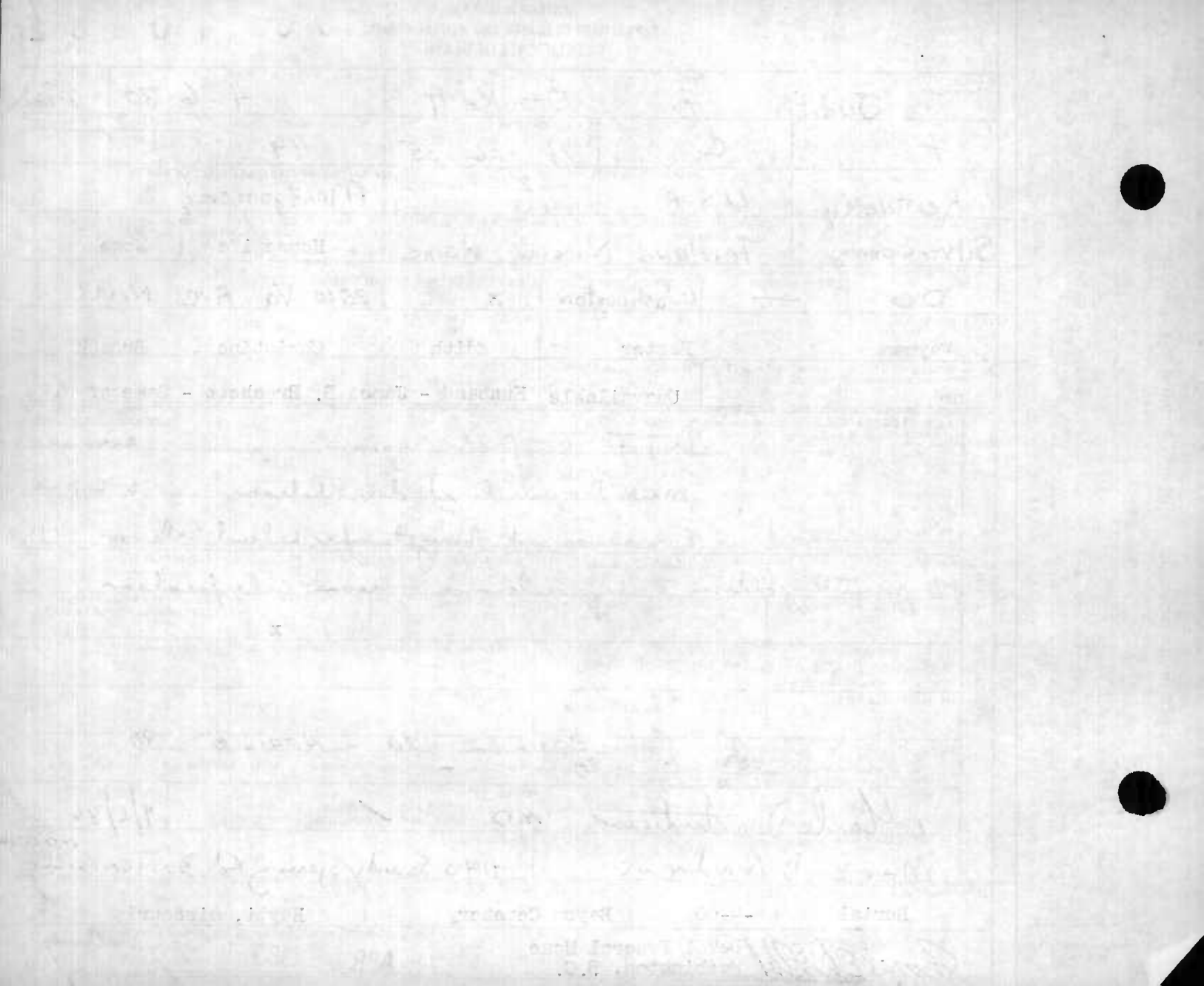
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8010582		
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Judith 7. Brockett			2a. DATE OF DEATH MONTH DAY YEAR 4-6-80			2b. HOUR 6:30 PM			
3. SEX 7		4. RACE C		5. DATE OF BIRTH MONTH DAY YEAR 11 26 35		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS 44 YRS.			IF UNDER 1 YEAR IF UNDER 24 HRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS) Fairland Nursing Home			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY None			
13a. STATE D.C.			13b. CITY OR TOWN Washington			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13d. STREET ADDRESS 2510 Va. Ave. N.W.			
14. FATHER'S NAME FIRST MIDDLE LAST Wayman			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith Christine Broach			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no			16b. SOCIAL SECURITY NO. Unavailable			
17. INFORMANT ADDRESS Husband - James B. Brockett - Same as #13			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UTI & prob. Sepsis</u> 3352 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Marked generalized debilitation</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>For advanced Amyotrophic Lateral Sclerosis</u> 14yr APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 3-6 mos			PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Hypertension & hypercalcemia + renal calcification</u>			19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from April 2, 1980, to April 6, 1980, that (I) (we) lost saw the deceased alive on April 6, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE Mark D. Andrews MD			22c. DATE SIGNED 4/6/80			22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mark D. Andrews			
22e. ADDRESS 4140 Sandy Spring Rd. Burtonsville MD 20830			23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4-9-80			23c. NAME OF CEMETERY OR CREMATORY Bayou Cemetery			
23d. LOCATION CITY OR TOWN Hayti, Missouri			24. FUNERAL DIRECTOR James E. DeVol			25a. DATE REC'D. BY REGISTRAR APR 14 1980			25b. REGISTRAR'S SIGNATURE Jeffrey McCready			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8010583			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LAVENIA FRANCES BRODEN				2b. HOUR 4:00P ^M			
3. SEX FEMALE		4. RACE NEGRO		5. DATE OF BIRTH MONTH DAY YEAR JULY 25 1924		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 55	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON DC		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO., BETHESDA MD	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY None	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND				13b. COUNTY MONTGOMERY			
13c. CITY OR TOWN SILVER SPR				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2200 ELLIS ST	
14. FATHER'S NAME FIRST MIDDLE LAST LEO WRIGHT				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EGUINA GURLEY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 578-26-5191		17. INFORMANT ADDRESS 2200 ELLIS ST SILVER SPRING MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cerebral hypoxia</u> 303- DUE TO, OR AS A CONSEQUENCE OF (b) <u>cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>chronic alcohol abuse</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (if (this hospital) attended the deceased from <u>Apr. 23</u> 19 <u>80</u> to <u>Apr. 26</u> 19 <u>80</u> , that (I) (we) lost the deceased alive on <u>Apr. 26</u> 19 <u>80</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.							
27a. SIGNATURE <u>James J. Curran</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		27c. DATE SIGNED Apr. 27, 1980	
27d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES J. CURRAN				27e. ADDRESS National Naval Medical Center, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-1-80		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Va.	
24. FUNERAL DIRECTOR NAME JOHN T. RINES & CO 3015 12TH ST WASH. DC				25a. DATE REC'D. BY REGISTRAR APR 30 1980		25b. REGISTRAR'S SIGNATURE <u>Robert M. Brady</u>	

covered by
brown sand
covered by water

James D. James
James D. James

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 10 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 10584	
1- STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) <i>Margaret Brooke</i>						2a. DATE KNOWN OF DEATH ESTIMATED <i>April 30, 1980</i>		2b. HOUR OF DEATH <i>10:48 AM</i>			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>June 23, 1924</i>		6. AGE (IN YEARS) LAST BIRTHDAY <i>55</i> YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD <i>April 30, 1980</i>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Ma</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery MD.</i>							
10. CITY OR TOWN OF DEATH <i>Olney</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Mont General Hosp</i>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Social Worker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Hospital</i>			
13a. STATE <i>Ma</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Spring</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>P. O. Box</i>					
14. FATHER'S NAME FIRST MIDDLE LAST <i>Charles Farquhar Brooke</i>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Cornelia Miller</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>				16b. SOCIAL SECURITY NO. <i>579 48 9305</i>		17. INFORMANT <i>Charles B. Henderson</i>				ADDRESS <i>314 Mansion Dr. Alexander Va</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Dis.</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. <i>Chronic Myocardial Dis.</i> (b) <i>Yrs.</i> (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Yrs.</i>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <i>None</i>													
19a. DATE OF OPERATION <i>None</i>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <i>John Rogers</i>						TITLE (SPECIFY) <i>Dep</i>		M.D. <i>Dep</i>		DATE SIGNED <i>April 30, 1980</i>			
EXAMINER'S NAME (TYPE OR PRINT) <i>John Rogers</i>						ADDRESS <i>Silver Spring Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>				23b. DATE <i>May 1 1980</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lee Funeral Home</i>				23d. LOCATION CITY OR TOWN COUNTY STATE <i>Washington D.C.</i>			
24. FUNERAL DIRECTOR NAME <i>Francis H. Barber</i>						ADDRESS <i>Laytonsville, Md.</i>		25a. DATE FILED BY REGISTRAR <i>May 3 1980</i>		25b. REGISTRAR'S SIGNATURE <i>Barbara Barber</i>			

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[illegible]

TO: DIRECTOR, FBI (100-388610) FROM: SAC, NEW YORK (100-100000) (P)
SUBJECT: JAMES EARL RAY; AKA; C. I. O. 100-100000

0 1970-01-01 Charles A. ...

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

8 0 1 0 5 8 5

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Margaret Ann BROWN <i>Margaret A. Brown</i>				2a. DATE OF DEATH MONTH DAY YEAR 4 25 '80		2b. HOUR 1:20 A.M.	
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 6 4 '86		6. AGE (IN YEARS LAST BIRTHDAY) 93	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. Baltimore		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sharon Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY own home	
13a. STATE MD				13b. CITY OR TOWN Glen Burnie		13c. STREET ADDRESS 904 Broadview Blvd.	
14. FATHER'S NAME FIRST MIDDLE LAST Stephen Musgrove				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia Phillips			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) XXXXXXXXXX 214-18-8274		17. INFORMANT ADDRESS Mrs. Ruth Stinchcomb (daughter)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiopulmonary arrest 4275 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE S. Withrow				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 4/25/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. WITHROW				22e. ADDRESS 15 East Deer Park Drive			
23a. BURIAL, CREMATION, REMOVAL (BY WHOM) Burial		23b. DATE 28 Apr. 80		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem PK		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie AA MD	
24. FUNERAL DIRECTOR Singleton Funeral Home				ADDRESS Glen Burnie, MD		25a. DATE REC'D. BY REGISTRAR APR 29 1980	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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0075-14

UNITED STATES GOVERNMENT

[Handwritten signature]

1960

IN WASHINGTON, D.C.

OFFICE OF THE DIRECTOR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WALTER E. BROWN			2a. DATE OF DEATH MONTH DAY YEAR April 28 '80		2b. HOUR P 7:15 M	
3. SEX MALE	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 5 3 1896	6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MASS.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Heuman Wilson Health Care Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Engineer		12b. KIND OF BUSINESS OR INDUSTRY American	
13a. STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS Standard 314 E. Melrose Avenue	
14. FATHER'S NAME FIRST MIDDLE LAST Charles A. Brown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Kingston		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		
16b. SOCIAL SECURITY NO 216-03-5460A		17. INFORMANT ADDRESS Mrs. Victor Poole, Mass.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) URemia 4409 DUE TO, OR AS A CONSEQUENCE OF (b) Nephrosis DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIO SCLEROSIS						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 MONTHS 7 YEARS 2 YEARS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (the hospital) attended the deceased from Oct 79 to 4/28 80 , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on 4/28 80 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> did (I) <input type="checkbox"/> did not view the body after death.						
22b. SIGNATURE Thos G. Ward		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/29/80
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thos G. Ward		22e. ADDRESS 6116 Robinwood, Bethesda, Md 20834				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/1/80		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Co., Md.
24. FUNERAL DIRECTOR NAME ADDRESS Henry W. Jenkins & Sons Co. 1905 York Road Balto., Md. 21212				25a. DATE REC'D. BY REGISTRAR MAY 1 1980		25b. REGISTRAR'S SIGNATURE Patricia C. B...

WALTER E. KROWN
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WALTER E. KROWN
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

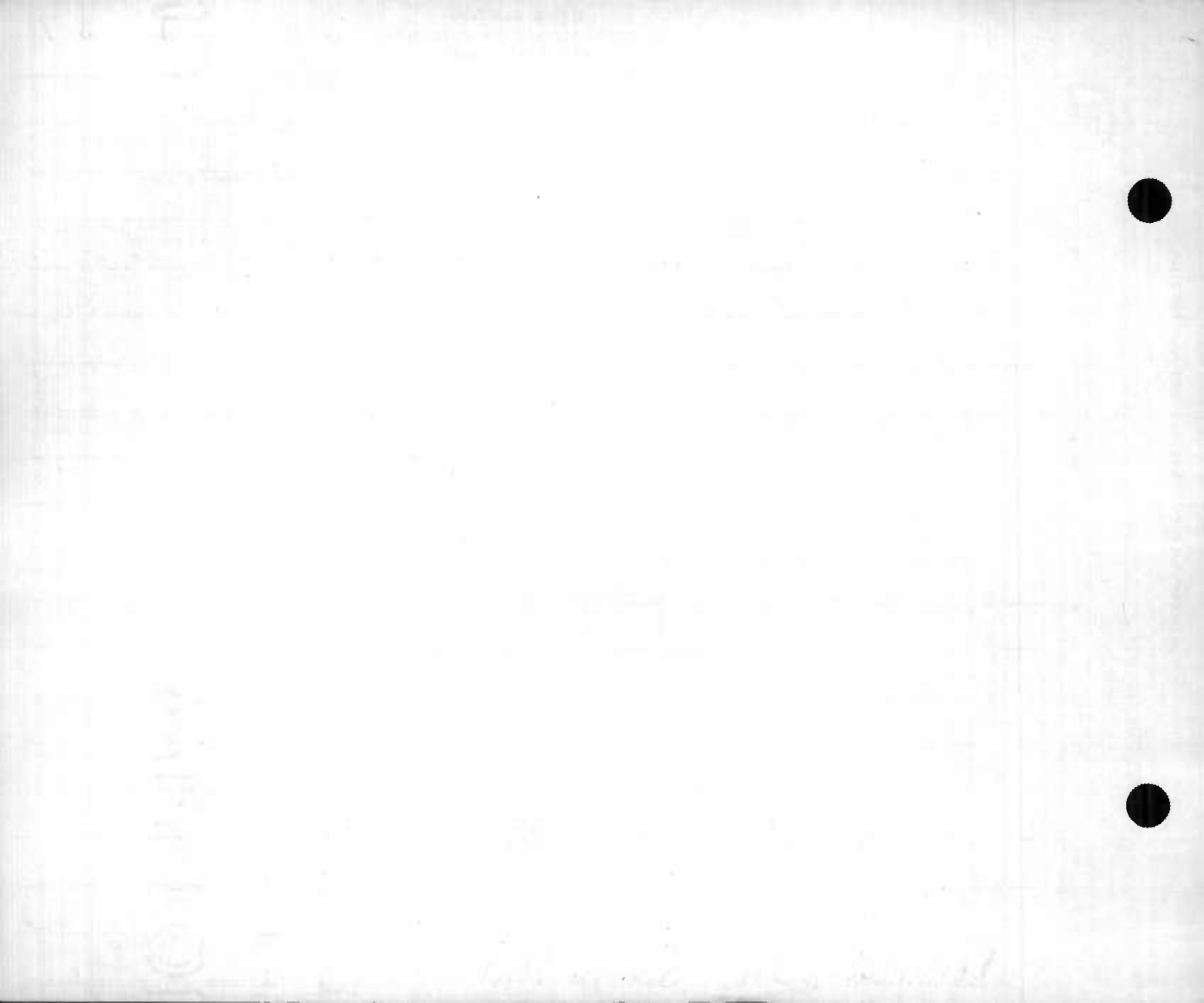
8 0 1 0 5 8 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WALTER LEE BRYAN			2a. DATE OF DEATH MONTH DAY YEAR 4-23-1980			2b. HOUR 7:15 P.M.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 7-27-1918		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH TAKOMA PK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bulldozer operator		12b. KIND OF BUSINESS OR INDUSTRY Construction	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Md.		13c. COUNTY Mont-P-G.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3636 GREEN CASTLE ROAD.	
14. FATHER'S NAME FIRST MIDDLE LAST WALTER BRYAN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH BOND.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 579-09-5354		17. INFORMANT NIFE - AS ABOVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hepato-renal syndrome</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>End stage Chronic Cirrhosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic alcoholism</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3d 5-10 yrs 7-20 yrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Severe GI bleed 2° to varices, ascites, AODM</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Mark D Andrews MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/23/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mark D Andrews		22e. ADDRESS 4140 Sandy Spring Rd Burtonsville MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE APRIL 26 1980		23c. NAME OF CEMETERY OR CREMATORY Union Cem		23d. LOCATION CITY OR TOWN COUNTY STATE BURTONSVILLE MD	
24. FUNERAL DIRECTOR NAME Donald J. H.		ADDRESS Laurel Md		25a. DATE REC'D. BY REGISTRAR APR 30 1980		25b. REGISTRAR'S SIGNATURE Hickory McCready	

BP

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(VRA 15, 4) 7/78





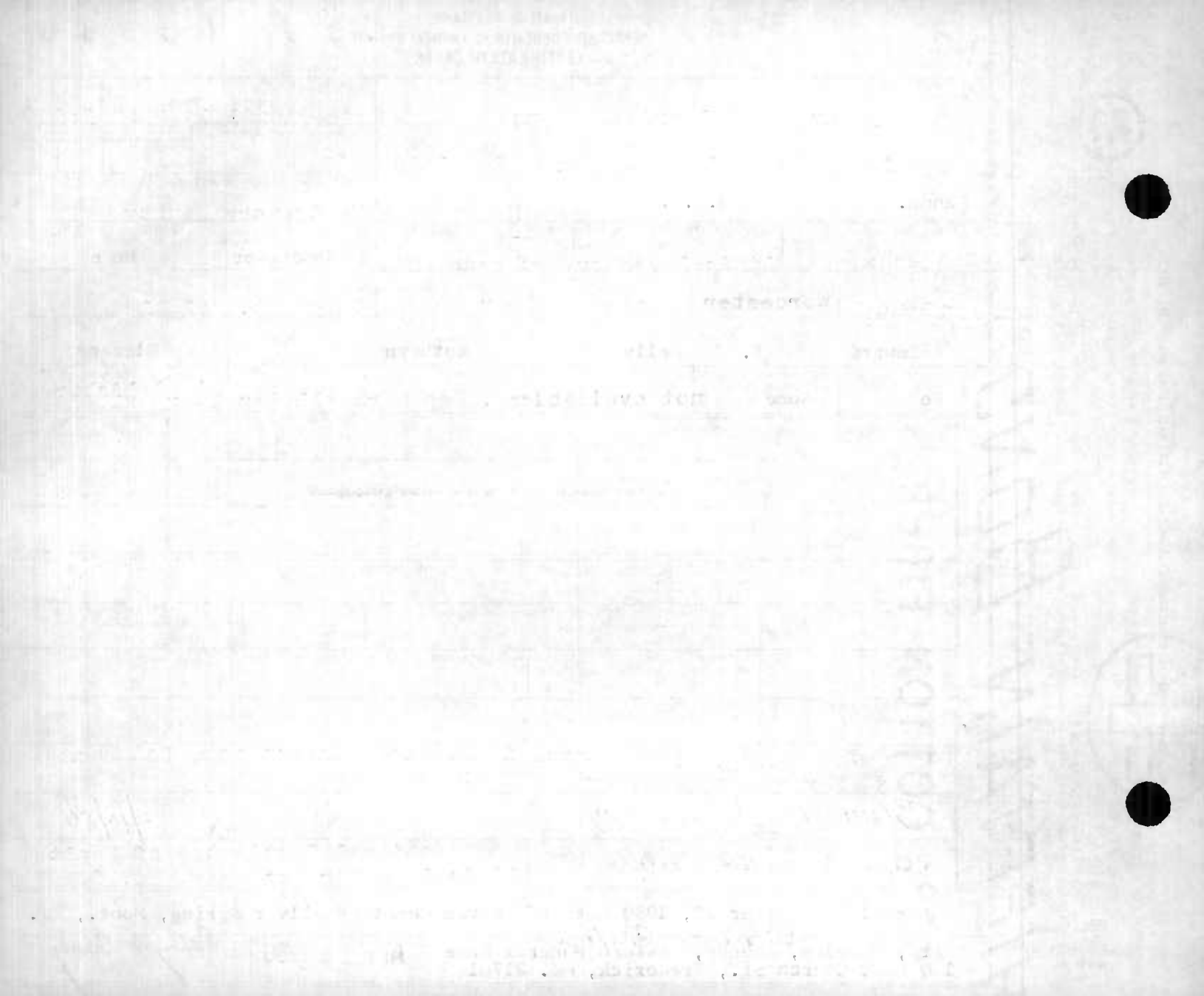
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Dorothy Delourdes Buck					2a. DATE OF DEATH MONTH DAY YEAR April 10, 1980			2b. HOUR 9:55 A.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 30, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinical Center, Bethesda, Md. NIH				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Worcester 13c. CITY OR TOWN Berlin					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5 Bay St. 21811		
14. FATHER'S NAME FIRST MIDDLE LAST Edward F. Kelly					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kathryn Gleason				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Rt. 6 Box 627 Salisbury, Md. 21801 Dee Marshall, daughter					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> <u>1509</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of the Esophagus</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>1 month</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>None</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <input checked="" type="checkbox"/>			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>March 20</u> , 19 <u>80</u> , to <u>April 10</u> , 19 <u>80</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>April 10</u> , 19 <u>80</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above, <u>or</u> (we) (did) <u>not</u> view the body after death.									
22b. SIGNATURE <u>Bruce A. Silver</u> M.D.					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <u>4/10/80</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BRUCE A. SILVER M.D.					22e. ADDRESS National Institutes of Health, Clinical Center, Bethesda, Md. 20205				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Apr 12, 1980		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Mont., Md.			
24. FUNERAL DIRECTOR Smith, Fadeley, Keeney, Bassford Funeral Home 106 East Church St., Frederick, Md. 21701					25a. DATE REC'D. BY REGISTRAR APR 15 1980		25b. REGISTRAR'S SIGNATURE <u>Patricia A. Brady</u>		

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 1 0 5 8 9

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Nettie Mae Burgess			2a. DATE OF DEATH MONTH DAY YEAR 4 3 80			2b. HOUR 3:15 P.M.				
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR 10 2 87		6 AGE (IN YEARS LAST BIRTHDAY) 92 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Iowa		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Broker		12b. KIND OF BUSINESS OR INDUSTRY Real Estate				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE D.C.			13b. COUNTY Washington			13c. CITY OR TOWN Washington			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST George A. Deal			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Mary Miller			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				
16b. SOCIAL SECURITY NO. 579-01-3875			17 INFORMANT ADDRESS Bethesda, MD			18. MARGUERITE STUART, 6408 82nd PLACE				
11 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrest								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 MIN		
4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) cardiac failure								6 YRS		
DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerotic heart disease								15 YRS		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Respiratory distress										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 6/15 , 19 65 , to 4/3 , 19 80 , that (I) (we) last saw the deceased alive on 4/3 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Thomas F. O'Connor M.D.			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/3/80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS F. O'CONNOR M.D.			22e. ADDRESS 8218 WILSON AVE BETHESDA MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/8/80		23c. NAME OF CEMETERY OR CREMATORY Parklawn Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland			
24 FUNERAL DIRECTOR NAME ADDRESS Robert A. Humphrey Funeral Homes, P.A. Bethesda, Maryland			25a. DATE REC'D. BY REGISTRAR APR 9 1980			25b. REGISTRAR'S SIGNATURE Henry H. Bandy				

0001 0002

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 1 0 5 9 0			
1. FOR STATE REGISTRAR		REG. NO.											
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
ANNE CORA		ANNE		BURKE				4-21-80					8 ²⁵ P ^M
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7a. UNDER 1 YEAR		7b. UNDER 24 HRS			
FEMALE		WHITE		OCT. 14 1884		95 YRS.		MONTHS		DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH							
VIRGINIA		U.S.A.				Montgomery County MD.							
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Silver Spring		Holy Cross Hospital		DEPARTMENT STORE		WOODWARD & LOHR							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
MD		MONT		TERRA PARK		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		8005 GARLAND AVE					
14 FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
JAMES		CORA											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS							
NO		577-01-4492		CAROL C. UNGER		8005 GARLAND AVE. T.P.							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> 4409 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypostatic pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic organic brain syndrome.</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		24 hr. 48 hr. 10 years.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <u>Arteriosclerotic vascular disease</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (1) this hospital attended the deceased from 4/1 1980, to 4/21 1980, that (2) (we) last saw the deceased alive on 4/21 1980, and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (3) (we) (did) (did not) view the body after death.													
22b. SIGNATURE James R. Coleman MD.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/21/80							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES R. COLEMAN		22e. ADDRESS 9241 COLUMBIA BLVD SILVER SPRING, MARYLAND 20910.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial		April 24, 1980		Warrinton Cemetery		Warrinton Virginia							
24. FUNERAL DIRECTOR Bettar Walters		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Patty McCreedy									
		APR 24 1980											



[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 1 0 5 9 1			
1. FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) Bruce E. BURKE			2a. DATE OF DEATH MONTH DAY YEAR April 5, 1980			2b. HOUR 1:09P M	
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Jan. 1, 1909		6 AGE (IN YEARS LAST BIRTHDAY) 71 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co., MD.	
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Meat Inspector		12b KIND OF BUSINESS OR INDUSTRY State of Md.	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Gaithersburg		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST William H. Burke		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hettie P. Johnson		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b SOCIAL SECURITY NO. 579-01-0283		17 INFORMANT Mary L. Burke,		17 ADDRESS Item 13			
11 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation 410- DUE TO, OR AS A CONSEQUENCE OF (b) A.M.I. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) A.S.H.D. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes Minutes Years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Diabetes Mellitus, Previous M.I.s + C.H.F.							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION CITY OR TOWN COUNTY STATE			
22 I certify that (I) (this hospital) attended the deceased from 19 67 to 4-5 19 80 , that (I) (we) last saw the deceased alive on 2-26 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22a SIGNATURE Jack Schumacher M.D.				DEGREE M.D.		22c DATE SIGNED April 5, 1980	
22b PHYSICIAN'S NAME (TYPE OR PRINT) Jack Schumacher, M.D.				22e ADDRESS 105 Russell Ave., Gaithersburg, Md.			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Apr. 8, 1980		23c NAME OF CEMETERY OR CREMATORY Laytonsville		23d LOCATION CITY OR TOWN COUNTY STATE Laytonsville, Montg., Md.	
24 FUNERAL DIRECTOR NAME Olin L. Molesworth, Damascus, Md.				25a. DATE REC'D. BY REGISTRAR APR 8 1980		25b REGISTRAR'S SIGNATURE Pietro Melchior	

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2017.11.17

601-9527/29

• • •

• 11 20 64571 70739071 2 10

Signature: _____ Date: _____

no "undo,"

6170

2.2.2

• **Answer:** A

NOTES

(continued)

See 1-12-72

• *Journal of the American Medical Association*, 1997; 277: 1001-1005

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[illegible]

1. *Chlorophyll a* (Chl a) is the primary photosynthetic pigment in most plants and algae. It is a green pigment that absorbs light energy in the blue and red regions of the visible spectrum. Chl a is essential for the light-dependent reactions of photosynthesis, where it converts light energy into chemical energy in the form of ATP and NADPH.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO. 8010592						
1 DECEASED NAME (TYPE OR PRINT)			2a DATE OF DEATH			MONTH DAY YEAR		2b HOUR	
James Oliver Burroughs			04/06/80				1:25 P.M.		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR	
Male		White		Aug. 21, 1905		74		MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Md.		USA				Montgomery County MD.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Olney		Montgomery General Hospital				Greens Keeper		Golf Club	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13b. INSIDE CITY LIMITS?		13c STREET ADDRESS		
13a STATE 13b. COUNTY 13c. CITY OR TOWN					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		11922 Queens St.		
14 FATHER'S NAME					15 MOTHER'S MAIDEN NAME				
George Edward Burroughs					Barbara - Peters				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS				
no			212-12-4924		Paul Burroughs 3201 Damascus Rd. Brookeville, Md. 20729				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of prostate</u> 185- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Carcinoma of prostate, previously treated.</u>									
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>3/26</u> , 19 <u>80</u> , to <u>4/6</u> , 19 <u>80</u> , that (I) <u>was</u> lost saw the deceased alive on <u>4/6</u> , 19 <u>80</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I <u>was</u> did not) view the body after death.									
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
<u>Dr. J. Lodmell</u>								4/7/80	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
BURIAL			April 9, 1980		Gate of Heaven		Silver Spring Mont. Md.		
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Francis H. Barber Laytonsville, Md. 20760						APR 10 1980		<u>James H. Brady</u>	

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) BERTHA L. BURTON			2a. DATE OF DEATH MONTH DAY YEAR April 3, 1980			2b. HOUR 2:10 P.M.					
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR December 18, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.					
10. CITY OR TOWN OF DEATH Silver Spring, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Colonial Park Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
13a. STATE MARYLAND		13b. COUNTY MONTG.		13c. CITY OR TOWN Silver Spring		13e. STREET ADDRESS 12325 New Hampshire Ave.					
14. FATHER'S NAME FIRST MIDDLE LAST Benjamin F. Potts			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma F. Ashton								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 578-20-7069A		17. INFORMANT ADDRESS Richard A. Burton 521 Mannakee St. Rockville, Maryland						
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure 4409 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH —			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 19 80 to present 19 80 , that (I) (we) last saw the deceased alive on April 1 19 80 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE D.B. Umhar MD DEGREE MD						22c. DATE SIGNED 4/5/80					
23a. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. B. Umhar MD						23b. ADDRESS 8805 Conn. Ave., Chevy Chase, Md.					
23c. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23d. DATE 4-7-80			23e. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem.			23f. LOCATION CITY OR TOWN COUNTY STATE Arlington Va.		
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland						25a. DATE REC'D. BY REGISTRAR APR 11 1980				25b. REGISTRAR'S SIGNATURE Henry McCready	

MEDICAL CERTIFICATION

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13325 New Hampshire Ave.
Silver Spring, Md.
F. Potts
F. Denton

No.

BURIAL
4-1-50
Robert J. Humphrey Funeral Home
F. R. Bethesda, Maryland
Arlington, Va.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 1 0 5 9 4	
1. FOR STATE REGISTRAR		CERTIFICATE OF DEATH			
DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	REG. NO.
MARY		B.	BURTON	2a. DATE OF DEATH	MONTH DAY YEAR
				April 20, 1980	2b. HOUR
					12:28 a
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR
Female	White	Nov. 9, 1902		77	IF UNDER 24 HRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
Illinois		USA		9. BALTIMORE CITY OR COUNTY OF DEATH	
				Montgomery MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Kensington	10115 Parkwood Terrace			Bookkeeper	Retail
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. INSIDE CITY LIMITS?		13b. STREET ADDRESS	
13a. STATE		13c. CITY OR TOWN		10115 Parkwood Terrace	
Maryland		Kensington			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
Eugene Bobb		Susan Meyers			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT (son) R.D. ADDRESS	
no		217-32-2097		Charles P. Burton Lebanon, NJ 08833	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Leukemia</u> 2089 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>1978</u> to <u>April 20</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>April 1</u> 19 <u>80</u> , and that in (I) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Fred A. Gill MD</u>		22c. DATE SIGNED <u>4/21/80</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
DR. Fred A. Gill		4743 Bradley Blvd.		Chevy Chase Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE	
Removal		4/20/80	George Washington Medical School	Washington DC	20015
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
Metropolitan Funeral Service		Alex, Va 22310		APR 23 1980	

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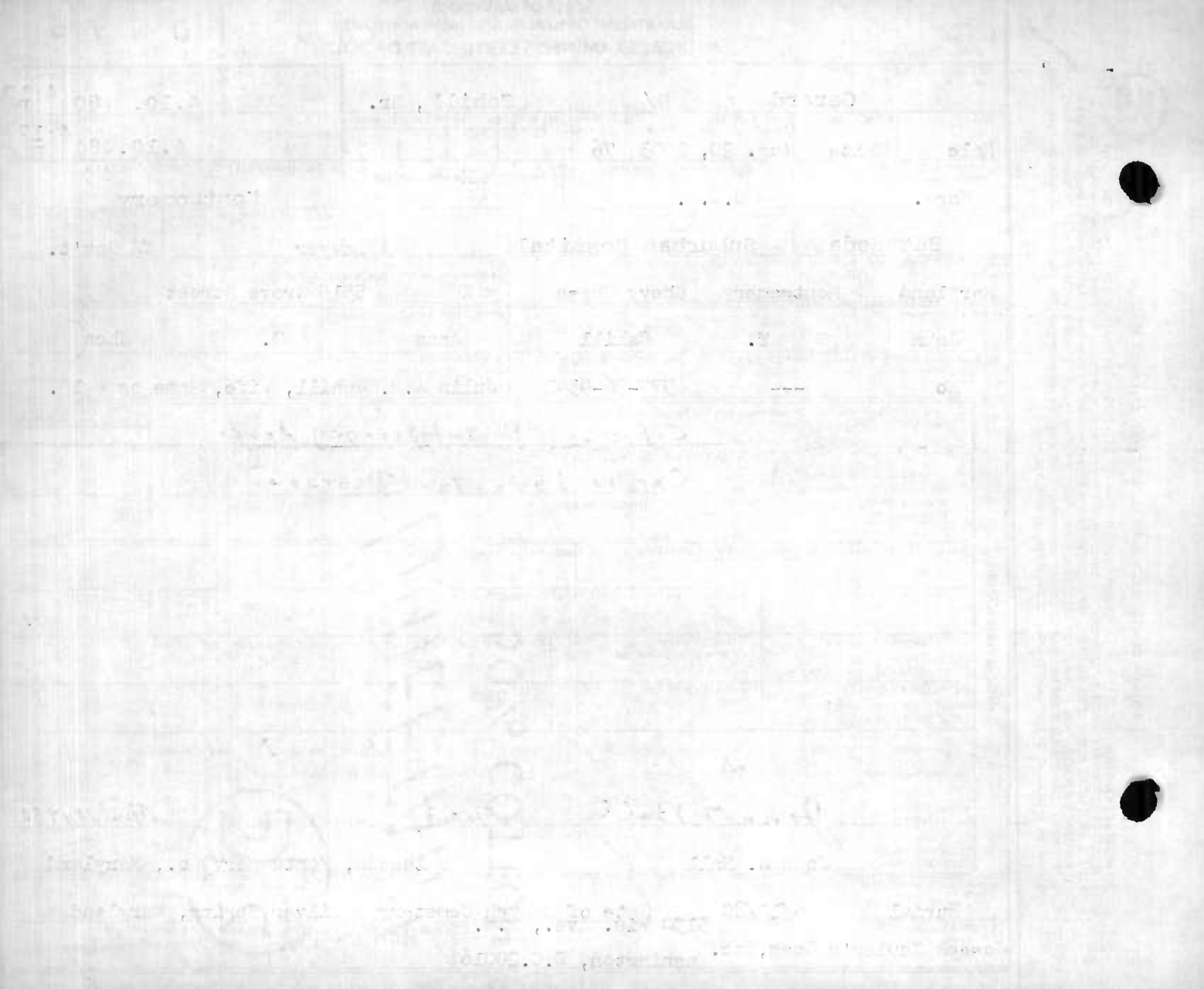
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 5. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 10595	
1. FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH	
1. DECEASED NAME FIRST MIDDLE LAST Gerard M/ Cahill, Sr.										2b. DATE ESTIMATED 4.10.1980 4:12 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 20, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD 4.10.1980 4:12 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Lawyer		12b. KIND OF BUSINESS OR INDUSTRY US Gov't.			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13e. STREET ADDRESS 5515 Grove Street					
14. FATHER'S NAME FIRST MIDDLE LAST John T. Cahill					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna G. Shea						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-36-9541		17. INFORMANT ADDRESS Julia A.R. Cahill, Wife, Same as # 13.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency Acute. 411- } Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Cardiac Vascular Disease (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John G. Ball				TITLE (SPECIFY) M.D. Deputy				DATE SIGNED April 10, 1980			
EXAMINER'S NAME (TYPE OR PRINT) John G. Ball				ADDRESS Bethesda, Montgomery Co., Maryland							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/12/80		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS Joseph Gawler's Sons, Inc. Washington, D.C. 20016				25a. DATE BY REGISTRAR APR 10 1980		25b. REGISTRAR'S SIGNATURE [Signature]					



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (S))
15M 7/76STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE KNOWN OF DEATH		2b. HOUR	
FIRST MIDDLE LAST		MONTH DAY YEAR		2b. HOUR	
Robert L. Carlson		04 28 1980		755 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.
Male	White	10 01 22	57 YRS.	MONTHS DAYS	HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	9. BALTIMORE CITY OR COUNTY OF DEATH		
Minn.	Minn.	NEVER MARRIED	Montgomery		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Rockville	Shady Grove Adventist Hosp.	Executive	NCR, Com-Ten		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Md.	Montgomery	Potomac	YES NO	10029 Colebrook Ave.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
Carl Carlson		Ruth Broberg			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes		WWI-Kor.-V. N. 477-16-4503		Lucille A Carlson, Wife. Same as item 13/	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) 411 - Coronary Insufficiency Acute.					
DUE TO, OR AS A CONSEQUENCE OF					
(b) Cardiovascular Disease.					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
Diabetes Mellitus.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES NO	
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION	
				STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
John G. Ball		Deputy		April 28 1980	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
John G Ball, M.D.		7936 Old Georgetown rd., Beth. Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		5/1/1980		Arlington National Cemetery	
				Arlington, Va.	
24. FUNERAL DIRECTOR NAME		25. MAY BE PREPARED BY		26. PREPARED BY	
Joseph Gawler's Sons Inc.		1980		John G. Ball	
5130 Wisc. Ave., N.W. Wash., D.C.					

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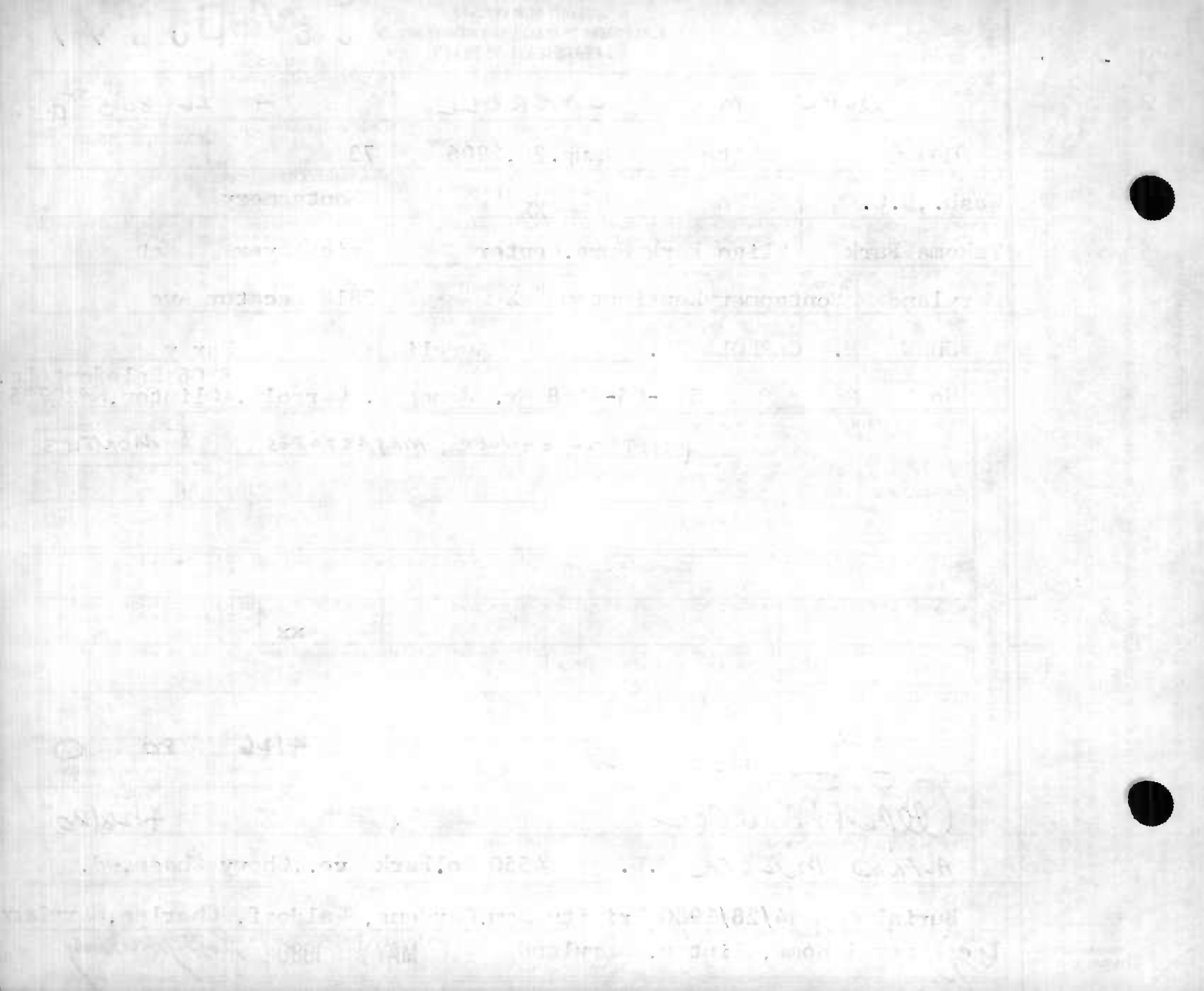
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. STATE REGISTRAR									
CERTIFICATE OF DEATH									
REG. NO. 80 10597									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN M. CARROLL					2a. DATE OF DEATH MONTH DAY YEAR 4 26 80		2b. HOUR 5 ⁵⁸ P.M.		
3. SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 26, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS		7. UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sligo Park Nurs. Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bricklayer		12b. KIND OF BUSINESS OR INDUSTRY Ret	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Kensington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3818 Decatur Ave	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN M. CARROLL SR.					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Aurelia Hardy				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO *****		17. INFORMANT ADDRESS 8106 BelefonteLa Mr. James A. Carroll, Clinton, Md 20735					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PROSTATIC CANCER, METASTASES									
DUE TO, OR AS A CONSEQUENCE OF (b)									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 4/22/80, 19 80, to 4/26/80, 19 80, that (I) (we) last saw the deceased alive on 4/22/80, and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)									
22b. SIGNATURE Alfred Muller				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 4/26/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALFRED MULLER M.D.				22e. ADDRESS 4550 SolPark Ave., Chevy Chase, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/28/1980		23c. NAME OF CEMETERY OR CREMATORY Trinity Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Waldorf, Charles, Maryland			
24. FUNERAL DIRECTOR Lee Funeral Home, Clinton, Maryland				25a. DATE REC'D. BY REGISTRAR MAY 2 1980		25b. REGISTRAR'S SIGNATURE [Signature]			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 1 0 5 9 8 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) MARION L. CARUANA				2a. DATE OF DEATH MONTH DAY YEAR 4 14 80				2b. HOUR 2:40 P.M.			
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR Nov. 30, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		7 UNDER 1 YEAR MONTHS DAYS		7 UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home maker		12b. KIND OF BUSINESS OR INDUSTRY none			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland				13c. COUNTY Prince Geo.		13d. CITY OR TOWN Lanham		13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13f. STREET ADDRESS 7211 Sunrise Drive	
14. FATHER'S NAME FIRST MIDDLE LAST Frederick P. Bush				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth L. Strong							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 577-18-3621		17. INFORMANT ADDRESS Lanham Zelda R. Potts, 7211 Sunrise Dr., Maryland					
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c): PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Sudden</u> <u>1 wk.</u>										APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>4/14/80</u> to <u>4/14/80</u> , that (I) (we) last saw the deceased alive on <u>4/14/80</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE Myron L. Lenkin				DEGREE		22c. DATE SIGNED 4/14/80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MYRON L. LENKIN				22e. ADDRESS 2309 SHOREFIELD RD WHEATON MD.		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE April 16, 1980		23c. NAME OF CEMETERY OR CREMATORY Mt. Comfort Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia			
24. FUNERAL DIRECTOR Beall Funeral Home 9013 Annapolis Road, Lanham, Maryland				25a. DATE REC'D. BY REGISTRAR APR 17 1980		25b. REGISTRAR'S SIGNATURE					

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FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE										MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) FELIX CASTELLON										2a. DATE KNOWN OF DEATH 4-13-80										2b. HOUR 4:38 PM									
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MAY 18, 1933		6. AGE (IN YEARS) 46 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD 4-13-80		7d. HOUR 4:38 PM		7e. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY													
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BOLIVIA				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY																	
10. CITY OR TOWN OF DEATH SILVER SPRING				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PHYSICIAN				12b. KIND OF BUSINESS OR INDUSTRY																	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. STATE MARYLAND										13b. COUNTY MONTGOMERY									
13c. CITY OR TOWN SILVER SPRING										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET ADDRESS 12221 CEDAR HILL DRIVE									
14. FATHER'S NAME MARTIANO CASTELLON										15. MOTHER'S MAIDEN NAME CLARA UNKNOWN																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO										16b. SOCIAL SECURITY NO. 579-76-7351										17. INFORMANT MARY CASTELLON ADDRESS SAME AS 13 WIFE									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4290 Diffuse Myocarditis IMMEDIATE CAUSE (a) 4290 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																													
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																													
ACTUAL SIGNATURE Richard L. Whelton										TITLE (SPECIFY) Deputy Medical Examiner										DATE SIGNED April 14, 1980									
EXAMINER'S NAME (TYPE OR PRINT) RICHARD L. WHELTON										ADDRESS 7100 Baltimore Ave College Park																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL										23b. DATE 4/17/80										23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN									
23d. LOCATION CITY OR TOWN SILVER SPRING										COUNTY MONT STATE MD.																			
24. FUNERAL DIRECTOR FRANCIS J. COLLINS										25a. DATE REC'D. BY REGISTRAR APR 17 1980										25b. REGISTRAR'S SIGNATURE Barney McCreedy									
NAME 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901																													

220 UNIT. BLVD. U.S. SILVER SPRING, MD. 20901
 FRANCIS J. COLLINS
 4/17/80 DATE OF BIRTH
 SILVER SPRING MD
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[Faint, illegible handwritten text and markings]

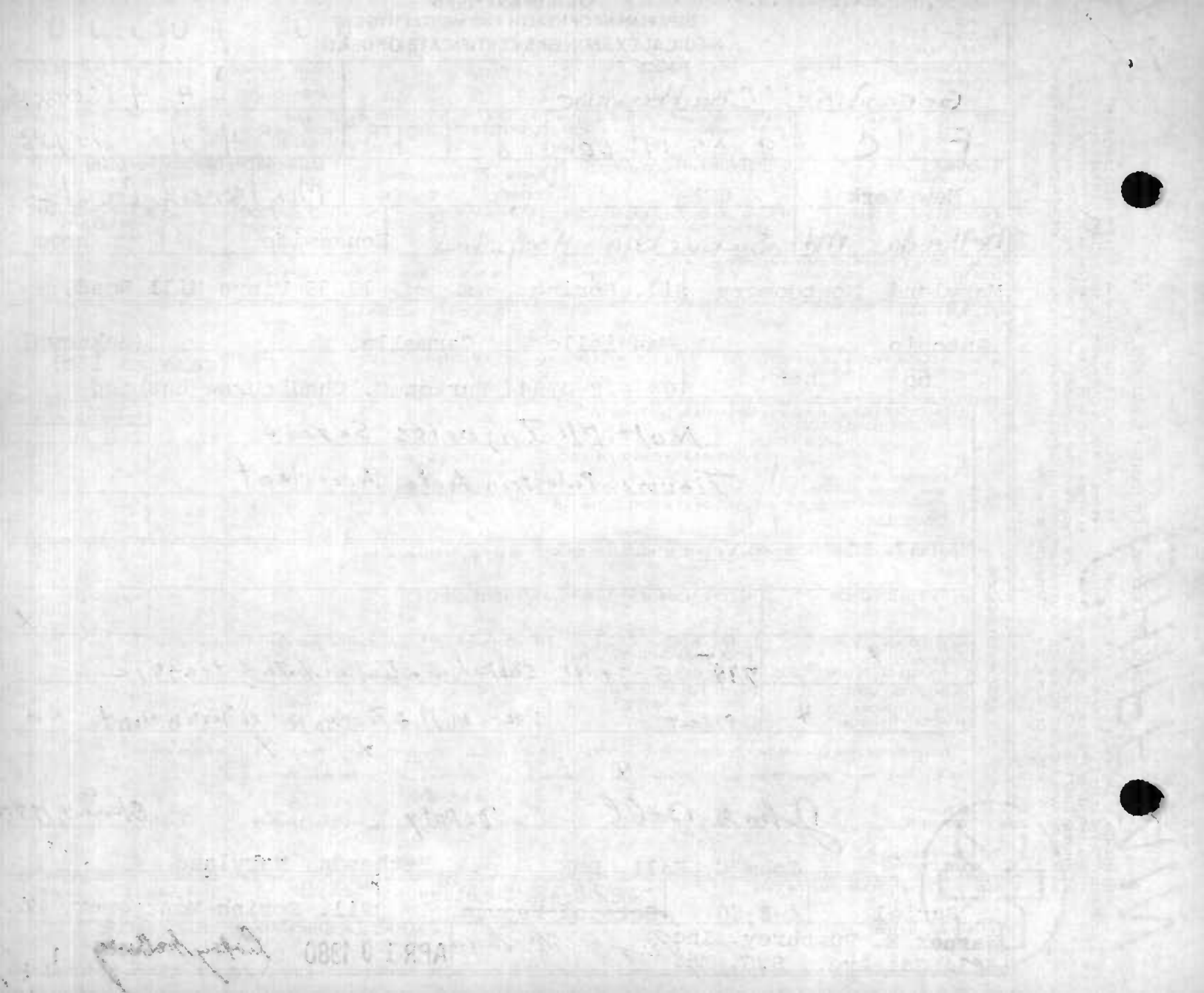
NO 229-18-7321 MAY CASTLETON SAME AS 12 DATE
 MARYANN CASTLETON CLARA UNKNOWN

MARYANN MONTGOMERY SILVER SPRING XX 1221 CRANE HILL DRIVE
 SILVER SPRING HOLLYWOOD C.2.A. UNKNOWN
 WHITE MAY 12, 1935 12

FELIX CASTLETON 4-13-35

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 10600	
1. DECEASED NAME (TYPE OR PRINT) E. Chadbourne										2a. DATE KNOWN OF DEATH 4 4 1980	
3. SEX F 4. RACE C 5. DATE OF BIRTH 9 05 19 60 6. AGE (IN YEARS) 60 7. IF UNDER 1 YR. MONTHS DAYS 8. IF UNDER 24 HRS. HOURS MIN.										2b. DATE PRONOUNCED DEAD 4-4 1980	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD		
10. CITY OR TOWN OF DEATH Bethesda Md			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY own home		
13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Sil. Spring 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 12039 Viers Mill Road,											
14. FATHER'S NAME Antonio Manniello					15. MOTHER'S MAIDEN NAME Carmella (unknown)						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no					16b. SOCIAL SECURITY NO. 043-22-0794					17. INFORMANT Burton M. Chadbourne-husband	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries Severe. DUE TO, OR AS A CONSEQUENCE OF (b) Trauma. Pedestrian Auto. Accident. DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY 7:15 P.M. 3-24-1980				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Struck in street on path of traffic			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Street				21f. LOCATION Viers Mill & Ferrara Rd. Wheaton Mont. Md			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John S. Ball				TITLE (SPECIFY) Deputy				DATE SIGNED April 4, 1980			
EXAMINER'S NAME (TYPE OR PRINT) John G. Ball, DME				ADDRESS Bethesda, Maryland							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4-8-80		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery Gate of Heaven			23d. LOCATION CITY OR TOWN Sil. Spring COUNTY Montgomery STATE Md.			
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.						25a. DATE REC'D. BY REGISTRAR APR 10 1980			25b. REGISTRAR'S SIGNATURE L. J. McShane		
8434 Ga. Ave., S.S. Md.											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 1 0 6 0 1	
1- FOR STATE REGISTRAR		CERTIFICATE OF DEATH								REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Joseph Vincent Chirichella						2a. DATE OF DEATH MONTH DAY YEAR 4 - 27 - 1980				2b. HOUR 11:30 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 9 1933		6. AGE (IN YEARS LAST BIRTHDAY) 46 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IS NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cab Driver-Self Employed		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.						13b. COUNTY Mont.		13c. CITY OR TOWN S.S.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Pasquale Chirichella						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary UNK					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korean		17. INFORMANT Same as above		17. ADDRESS Barbara A. Chirichella (Wife)					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LUNG & METASTASES 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH APPROX 1 1/2 YRS.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 4/19 19 80 to 4/25 19 80 , that (I) (we) last saw the deceased alive on 4/25 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.											
22b. SIGNATURE Joseph B. Mizgerd, MD						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/28/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH B. MIZGERD, MD						22e. ADDRESS 7600 CARROLL AVE, TAKOMA PARK, MD. 20012					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/1/80		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood PG Md.					
24. FUNERAL DIRECTOR NAME ADDRESS Hines/Rinaldi F.H.11800 N.H.Ave.S.S.Md.						25a. DATE REC'D. BY REGISTRAR APR 29 1980		25b. REGISTRAR'S SIGNATURE Mickey McCreedy			

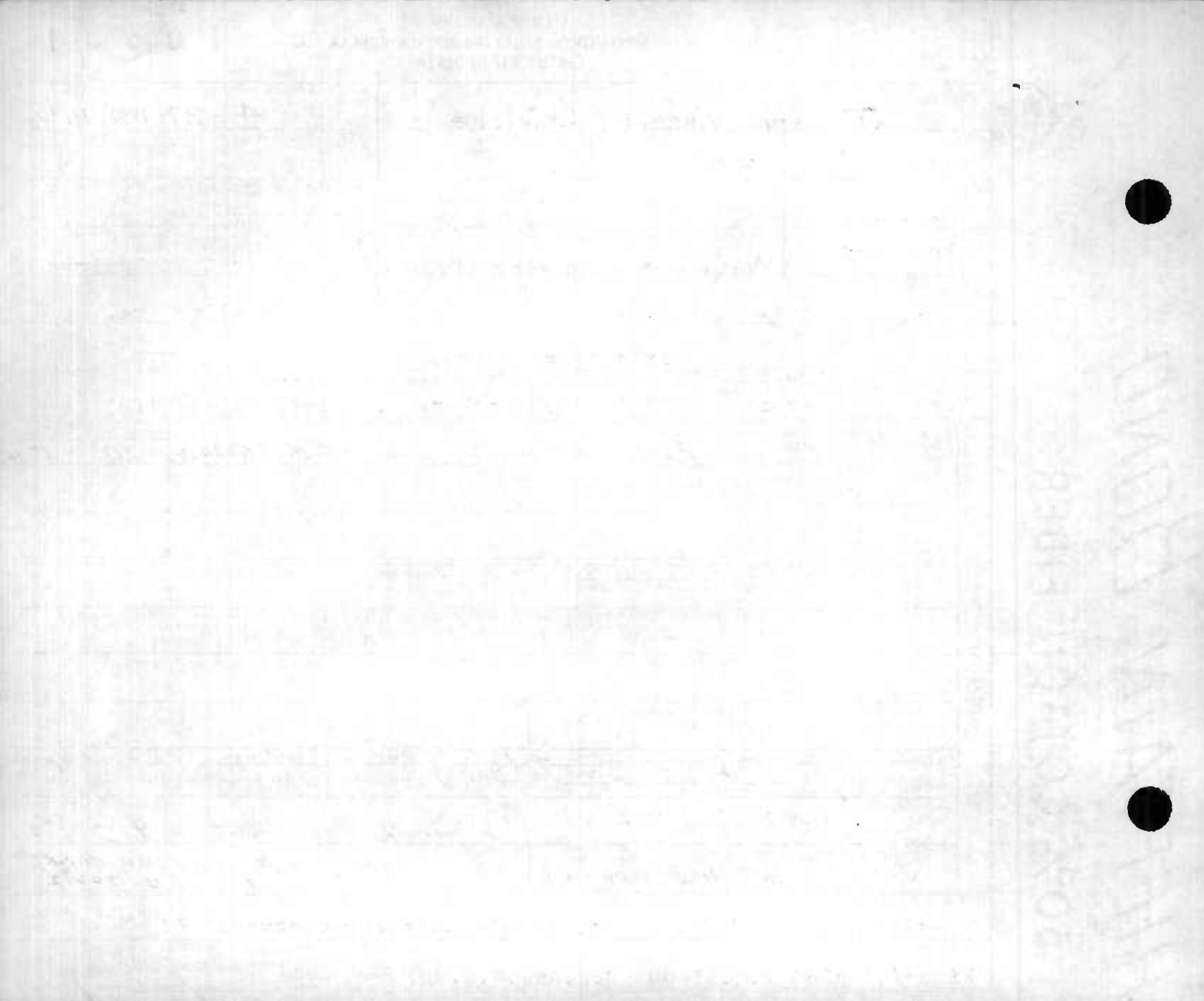
MEDICAL CERTIFICATION

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR AIS ME (5))
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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 10602	
1. DECEASED NAME (TYPE OR PRINT) Armand C. Cioccio										2a. DATE KNOWN OF DEATH ESTIMATED April 12 1980	
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR May 18 1951	6. AGE (IN YEARS) LAST BIRTHDAY 29 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	7c. DATE PRONOUNCED DEAD April 12 1980	2b. HOUR 5:30 PM					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.						
10. CITY OR TOWN OF DEATH Sil. Spg.		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ELECTRONIC ENGINEER U.S. GOVT		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE MD		13b. COUNTY Mont.		13c. CITY OR TOWN Sil. Spg.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3406 Fredrick St.				
14. FATHER'S NAME FIRST MIDDLE LAST JOHN CIOCCIO				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NATHALIA MONACO							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) UNIT 175-18-4444		17. INFORMANT MARY JANE CIOCCIO		ADDRESS SAME AS 13 WIFE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dis. 4291 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Chronic Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Yrs											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None											
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John S. Rogers		TITLE (SPECIFY) M.D. Dep.		MEDICAL EXAMINER		DATE SIGNED April 12 1980					
EXAMINER'S NAME (TYPE OR PRINT) JOHN S. ROGERS		ADDRESS 1919 SEMINARY ROAD, SILVER SPRING, MD.									
23a. BURIAL, CREMATION, REMOVAL (S) BURIAL		23b. DATE 4/16/80		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD.					
24. FUNERAL DIRECTOR NAME ADDRESS FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901				25a. DATE REC'D. BY REGISTRAR APR 17 1980		25b. REGISTRAR'S SIGNATURE Robert McCreedy					

FIGURE 2.4.1. REMOTE DYNAMICS

CONCLUSIONS

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201
Released by Dr. Mayle to Dr. Jumban
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 1 0 6 0 3			
1- FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
GRACE M. CLARK				4-15-80 3P			
3. SEX Female		4. RACE White		5. DATE OF BIRTH 10-29-1897		6. AGE (IN YEARS 'LAST BIRTHDAY) 82	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maine		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO. MD.	
10. CITY OR TOWN OF DEATH BETHESDA, MD.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.	
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME Edwin		15. MOTHER'S MAIDEN NAME Gertrude		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO 159-10-2816	
				17. INFORMANT Lena C Eagan Same as item 13 (Sister)		18. ADDRESS 7000 Maple Ave.	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC LOW GRADE INTESTINAL 5609 DUE TO, OR AS A CONSEQUENCE OF (b) SEVERE KYPHOSCOLIOSIS obstruction DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH > 6 WKS							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 6/6 19 75 to 4/15/ 19 80 (that (I) (we) lost saw the deceased alive on 4/15 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE John B. Jumban MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/16/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John B. Jumban MD				22e. ADDRESS 8805 Comp. Ave. Chevy Chase Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/21/1980		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington D.C.	
24. FUNERAL DIRECTOR Joseph Gawler's Sons Inc. NAME ADDRESS 5130 Wisc. Ave., N.W. Wash., D.C.				25a. DATE REC'D. BY REGISTRAR APR 21 1980		25b. REGISTRAR'S SIGNATURE Morty McCreedy	

in a spirit of (1-2-3-4-5-6-7-8-9-10-11-12-13-14-15-16-17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-100-101-102-103-104-105-106-107-108-109-110-111-112-113-114-115-116-117-118-119-120-121-122-123-124-125-126-127-128-129-130-131-132-133-134-135-136-137-138-139-140-141-142-143-144-145-146-147-148-149-150-151-152-153-154-155-156-157-158-159-160-161-162-163-164-165-166-167-168-169-170-171-172-173-174-175-176-177-178-179-180-181-182-183-184-185-186-187-188-189-190-191-192-193-194-195-196-197-198-199-200-201-202-203-204-205-206-207-208-209-210-211-212-213-214-215-216-217-218-219-220-221-222-223-224-225-226-227-228-229-230-231-232-233-234-235-236-237-238-239-240-241-242-243-244-245-246-247-248-249-250-251-252-253-254-255-256-257-258-259-260-261-262-263-264-265-266-267-268-269-270-271-272-273-274-275-276-277-278-279-280-281-282-283-284-285-286-287-288-289-290-291-292-293-294-295-296-297-298-299-300-301-302-303-304-305-306-307-308-309-310-311-312-313-314-315-316-317-318-319-320-321-322-323-324-325-326-327-328-329-330-331-332-333-334-335-336-337-338-339-340-341-342-343-344-345-346-347-348-349-350-351-352-353-354-355-356-357-358-359-360-361-362-363-364-365-366-367-368-369-370-371-372-373-374-375-376-377-378-379-380-381-382-383-384-385-386-387-388-389-390-391-392-393-394-395-396-397-398-399-400-401-402-403-404-405-406-407-408-409-410-411-412-413-414-415-416-417-418-419-420-421-422-423-424-425-426-427-428-429-430-431-432-433-434-435-436-437-438-439-440-441-442-443-444-445-446-447-448-449-450-451-452-453-454-455-456-457-458-459-460-461-462-463-464-465-466-467-468-469-470-471-472-473-474-475-476-477-478-479-480-481-482-483-484-485-486-487-488-489-490-491-492-493-494-495-496-497-498-499-500-501-502-503-504-505-506-507-508-509-510-511-512-513-514-515-516-517-518-519-520-521-522-523-524-525-526-527-528-529-530-531-532-533-534-535-536-537-538-539-540-541-542-543-544-545-546-547-548-549-550-551-552-553-554-555-556-557-558-559-560-561-562-563-564-565-566-567-568-569-570-571-572-573-574-575-576-577-578-579-580-581-582-583-584-585-586-587-588-589-590-591-592-593-594-595-596-597-598-599-600-601-602-603-604-605-606-607-608-609-610-611-612-613-614-615-616-617-618-619-620-621-622-623-624-625-626-627-628-629-630-631-632-633-634-635-636-637-638-639-640-641-642-643-644-645-646-647-648-649-650-651-652-653-654-655-656-657-658-659-660-661-662-663-664-665-666-667-668-669-670-671-672-673-674-675-676-677-678-679-680-681-682-683-684-685-686-687-688-689-690-691-692-693-694-695-696-697-698-699-700-701-702-703-704-705-706-707-708-709-710-711-712-713-714-715-716-717-718-719-720-721-722-723-724-725-726-727-728-729-730-731-732-733-734-735-736-737-738-739-740-741-742-743-744-745-746-747-748-749-750-751-752-753-754-755-756-757-758-759-760-761-762-763-764-765-766-767-768-769-770-771-772-773-774-775-776-777-778-779-780-781-782-783-784-785-786-787-788-789-790-791-792-793-794-795-796-797-798-799-800-801-802-803-804-805-806-807-808-809-810-811-812-813-814-815-816-817-818-819-820-821-822-823-824-825-826-827-828-829-830-831-832-833-834-835-836-837-838-839-840-841-842-843-844-845-846-847-848-849-850-851-852-853-854-855-856-857-858-859-860-861-862-863-864-865-866-867-868-869-870-871-872-873-874-875-876-877-878-879-880-881-882-883-884-885-886-887-888-889-890-891-892-893-894-895-896-897-898-899-900-901-902-903-904-905-906-907-908-909-910-911-912-913-914-915-916-917-918-919-920-921-922-923-924-925-926-927-928-929-930-931-932-933-934-935-936-937-938-939-940-941-942-943-944-945-946-947-948-949-950-951-952-953-954-955-956-957-958-959-960-961-962-963-964-965-966-967-968-969-970-971-972-973-974-975-976-977-978-979-980-981-982-983-984-985-986-987-988-989-990-991-992-993-994-995-996-997-998-999-1000-1001-1002-1003-1004-1005-1006-1007-1008-1009-1010-1011-1012-1013-1014-1015-1016-1017-1018-1019-1020-1021-1022-1023-1024-1025-1026-1027-1028-1029-1030-1031-1032-1033-1034-1035-1036-1037-1038-1039-1

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 1 0 6 0 4

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary Elizabeth Cleary			2a. DATE OF DEATH MONTH DAY YEAR April 20, 1980		2b. HOUR 10:40 PM		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MAY 30, 1886		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MASSACHUSETTS		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1006 STROUT STREET		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BUYER		12b. KIND OF BUSINESS OR INDUSTRY WOODWARD & LOTH	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 1006 STROUT STREET		14. FATHER'S NAME FIRST MIDDLE LAST JOHN CLEARY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CATHERINE O'BRIEN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 577-01-4285		17. INFORMANT MARY C. THOMPSON		ADDRESS SAME AS 13 NIECE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4039 Congestive Heart Failure Chronic Cardiovascular Disease 54 years IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from April 19 70 to April 20 80 , that (I) (we) lost saw the deceased alive on April 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Robert H. Hale MD		22c. DATE SIGNED 20 April 80		22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT HALE			
22e. ADDRESS 5100 WISC., AVE., N.W., WASHINGTON, D.C.		22f. MEDICAL ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4/23/80		23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON, D.C.	
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS				25a. DATE REC'D. BY REGISTRAR APR 22 1980		25b. REGISTRAR'S SIGNATURE Robert H. Hale	
25c. ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BURIAL - FRANCIS J. COLLINS
 500 W. CLIVET, W. SILVER SPRING, MD. 20901

W. CLIVET CEMETERY, WASHINGTON, D. C.
 5100 WISC. AVE., N.W., WASHINGTON, D.C.

[Faint, illegible handwritten text, possibly a list or notes.]

10 277 01-4682 MARK C. THOMPSON SAFE AC 13 WIDE

JOHN CEEARY CATHERINE 1004 STREET STREET

HARRY AND MONTGOMERY STANLEY SPRING X X 1004 STREET STREET

MASSACHUSETTS U.S.A. MAY 30 1930

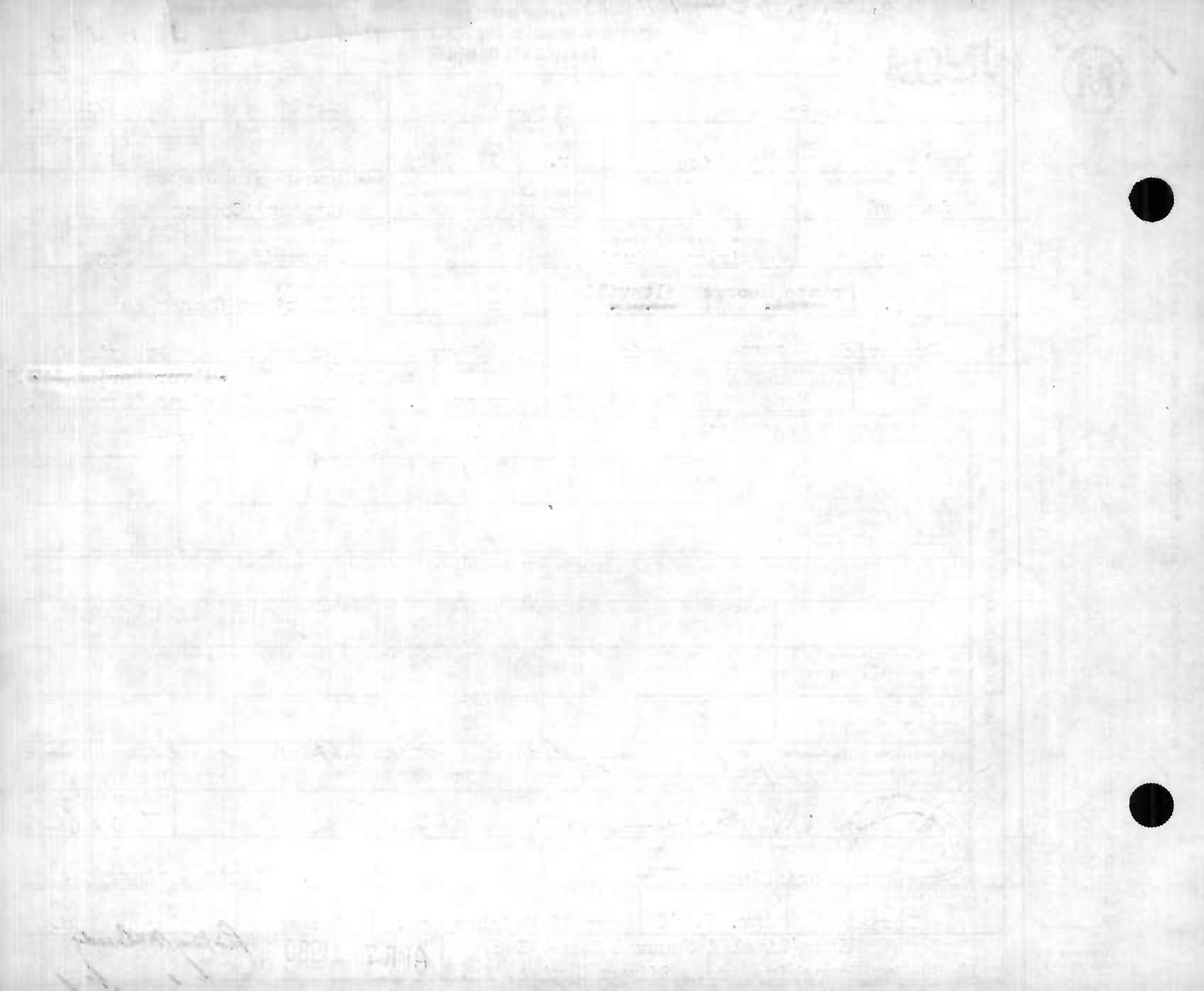
10-407 1004 ST. 1940

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 1 0 6 0 5	
1- FOR STATE REGISTRAR										CERTIFICATE OF DEATH	
REG. NO.											
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Juanita Clippard					2a. DATE OF DEATH MONTH DAY YEAR April 2, 1980			2b. HOUR 7:00 A.M.			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Apr. 19 1899		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fairland Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY None			
13a. STATE Md.					13b. COUNTY Mont.		13c. CITY OR TOWN Beltsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST Frederick Monroe Davis					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Catherine Etheridge					13e. STREET ADDRESS 4101 Briggs Chaney Road	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. None		17 INFORMANT (Daughter) Barbara C. Freeman		ADDRESS Beltsville Md. 20705 4101 Briggs Chaney Rd.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Vascular accident</u> 436- DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (the hospital) attended the deceased from <u>March</u> 19 <u>80</u> , to <u>April 2</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>April 1</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>John Marindino</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/3/80				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Marindino					22e. ADDRESS 11620 Kemp Mill Rd., Silver Spring, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Apr. 7, '80		23c. NAME OF CEMETERY OR CREMATORY Russell Heights Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Jackson Mo.				
24 FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home, Inc.					25a. DATE REC'D. BY REGISTRAR APR 7 1980		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				
11800 New Hampshire Ave., Silver Spring, Md.											



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

Items 18b&c 6543 5/22/80 dad STATE OF MARYLAND		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		3 0 1 0 6 0 6	
1. FOR STATE REGISTRAR		CERTIFICATE OF DEATH		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Emma Hall Emma Coe			2a. DATE OF DEATH MONTH DAY YEAR 04 14 80		2b. HOUR 2:00AM M
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 12 2 1890		6. AGE (IN YEARS LAST BIRTHDAY) 89 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Arkansas	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery Gen. Hosp. Olney		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife	12b. KIND OF BUSINESS OR INDUSTRY home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Unknown Hall			15. MOTHER'S MAIDEN NAME FIRST MIDDLE Arsulta Baker		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --		17. INFORMANT ADDRESS Willetta C. Chark same as 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> <u>410-</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF: (b) <u>CHF/MI</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u>Coronary artery disease</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>None</u>					
19a. DATE OF OPERATION <u>none</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>none</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>N/A</u> 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <u>none</u>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>William A. Schenck</u>				22c. DATE SIGNED 4/14/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. Schenck, M.D.				22e. ADDRESS M 614 187401 Pleasant Grove, Ark.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/16/80		23c. NAME OF CEMETERY OR CREMATORY Pleasant Grove Cemetery	
23d. LOCATION Tuckerman		23e. DATE REC'D. BY REGISTRAR APR 17 1980			
24. FUNERAL DIRECTOR Lyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Md. 20852					

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2024-2025

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by a registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8010607	
1 - FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HARRY C. COFFMAN						2a. DATE OF DEATH MONTH DAY YEAR 4/21/80			2b. HOUR 10 ⁵⁶ A M		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR OCT 15, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS		7. UNDER 1 YEAR MONTHS DAYS		7. UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD					
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ROUTE MANAGER		12b. KIND OF BUSINESS OR INDUSTRY WASH. POST			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN SILVER SPRING						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 12313 LA PLATA STREET			
14. FATHER'S NAME FIRST MIDDLE LAST JOHN COFFMAN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LILLIAN C ALVIN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-48-1913		17. INFORMANT MARGARET FANNING				ADDRESS SAME AS 13 DAUGHTER			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5829 Renal failure DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension + operation DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Glomerulo-nephritis many years										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks 1 month many years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c): Operation for Cancer of Rectum											
19a. DATE OF OPERATION 3-27-80		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cancer				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 3-25-80 1980, to 4-21-80 1980, that (I) (we) last saw the deceased alive on above, (I) (we) (and) did not view the body after death.											
22b. SIGNATURE A.F. CASTRO M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 4/22/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A.F. CASTRO M.D.				22e. ADDRESS 1125 Rockville Pike							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4/24/80		23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET			23d. LOCATION WASHINGTON, D. C. COUNTY STATE				
24. FUNERAL DIRECTOR NAME ADDRESS FRANCIS J. COLLINS 500 UNIV. BLVD. W. SILVER SPRING, MD. 20901				25a. DATE REC'D. BY REGISTRAR APR 22 1980		25b. REGISTRAR'S SIGNATURE Dorothy McCreedy					

21	OCT 12, 1928	WHITE	MALE
		U.S.A.	VERMONT
ROUTE 100			
1001 LA PLATA STREET	X	SILVER SPRING	MARYLAND
C ALVIN	LELLIAN	COFFMAN	JOHN
277-12-1912	MARGARET FAIRING		NO
SAME AS 12 DALLIES			

500 W. 11th St. N. SILVER SPRING, MD. 20901
 FRANCIS J. COLLINS
 4/24/60
 MT. OLIVET
 WASHINGTON, D. C.

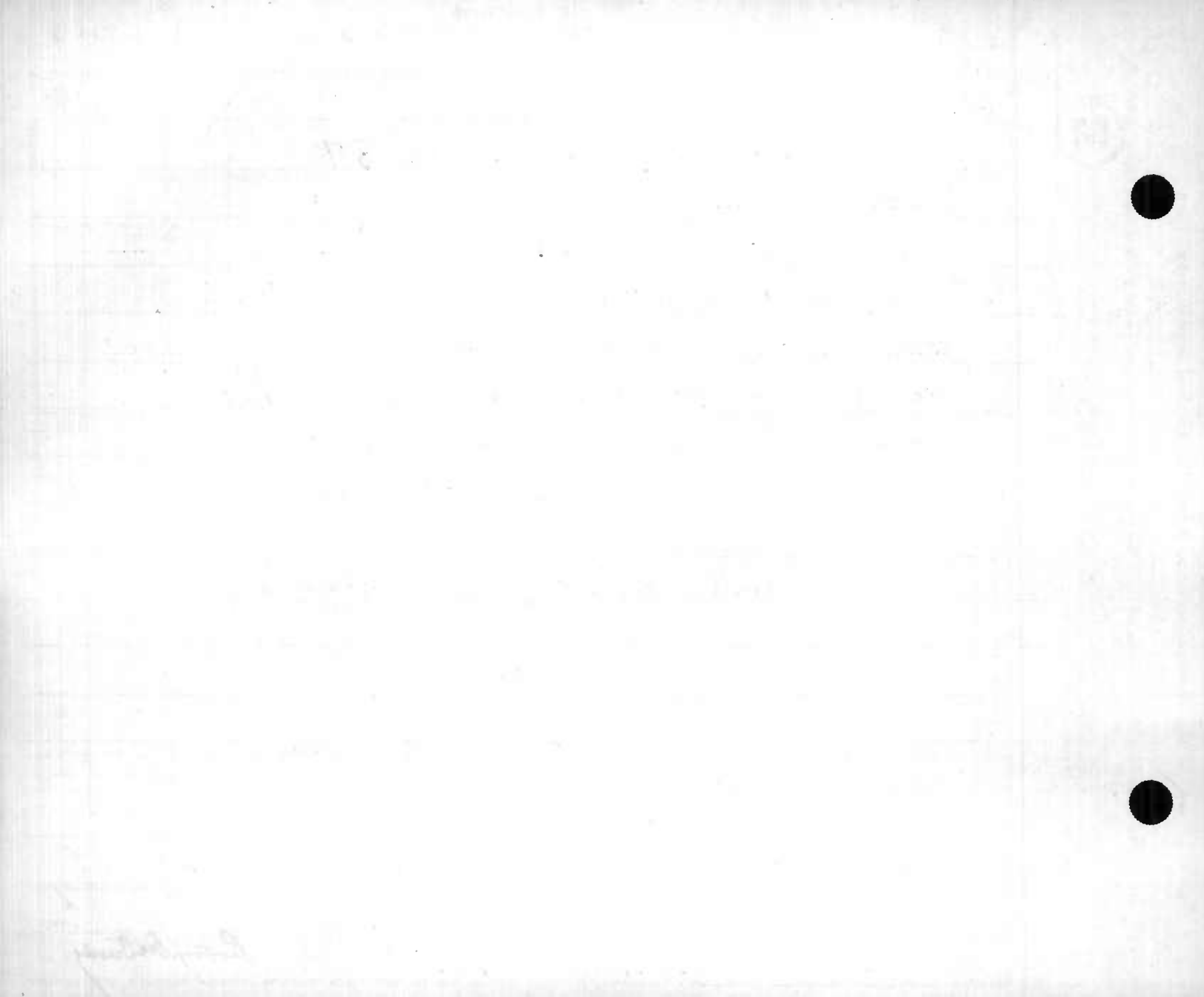


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR					8 0 1 0 5 0 8				
CERTIFICATE OF DEATH					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) HARRIET R. COHEN					2a. DATE OF DEATH MONTH DAY YEAR 4-4-80			2b. HOUR 6:15 M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 4-25-1892		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) COLLINGSWOOD NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY -----	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND					13b. COUNTY MONTGOMERY		13c. CITY OR TOWN ROCKVILLE		
14. FATHER'S NAME FIRST MIDDLE LAST Vivian Isadore Ettinger					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rachel Diamond				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578-52-1441D		17. INFORMANT ADDRESS MRS. HOWARD GOLDBERG, 11724 KEMP MILL RD SILVER SP. MD 20902					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Failure 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis (hardening of arteries) DUE TO, OR AS A CONSEQUENCE OF (c) 20 yrs APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Cardiovascular accident; Hypertension									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from August 1975 to April 1980 , that (I) (we) lost saw the deceased alive on 4/4 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John A. Galotto		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 4/1/80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John A. Galotto		22e. ADDRESS 5525 Poole Hill Rd, Bethesda, Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4/6/80		23c. NAME OF CEMETERY OR CREMATORY KING DAVID MEM. GAR.		23d. LOCATION CITY OR TOWN COUNTY STATE FALLS CHURCH VA.			
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEM. CH., ROCKVILLE, MD.				25a. DATE REC'D. BY REGISTRAR APR 8 1980		25b. REGISTRAR'S SIGNATURE Anthony M. Brady			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William H. Coleman					2a. DATE OF DEATH MONTH DAY YEAR 4/27/80			2b. HOUR MIN 12 ³⁰ A.M.	
3 SEX Male		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Oct. 10 1907		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Postal Carrier		12b. KIND OF BUSINESS OR INDUSTRY U.S. Service Postal	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Rockville					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 210 Woodland Rd.,		
14. FATHER'S NAME FIRST MIDDLE LAST William H. Coleman					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nettie Butt				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 577-10-3231		17. INFORMANT ADDRESS Annie V. Coleman (same as 13e)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery disease</u> (c) <u>probable acute myocardial infarct</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>4-21-1980</u> to <u>4-27-1980</u> , that (I) (we) last saw the deceased alive on <u>4-27-1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE H. Bahar					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4-27-80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HADI BAHAR					22e. ADDRESS 8218 Wisconsin Ave. Bethesda				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4-30-80		23c. NAME OF CEMETERY OR CREMATORY Darnestown Presby. Ch. Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Darnestown Montg. Md.	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY FUNERAL HOMES P/A					25. DATE REC'D. BY REGISTRAR MAY 6 1980				

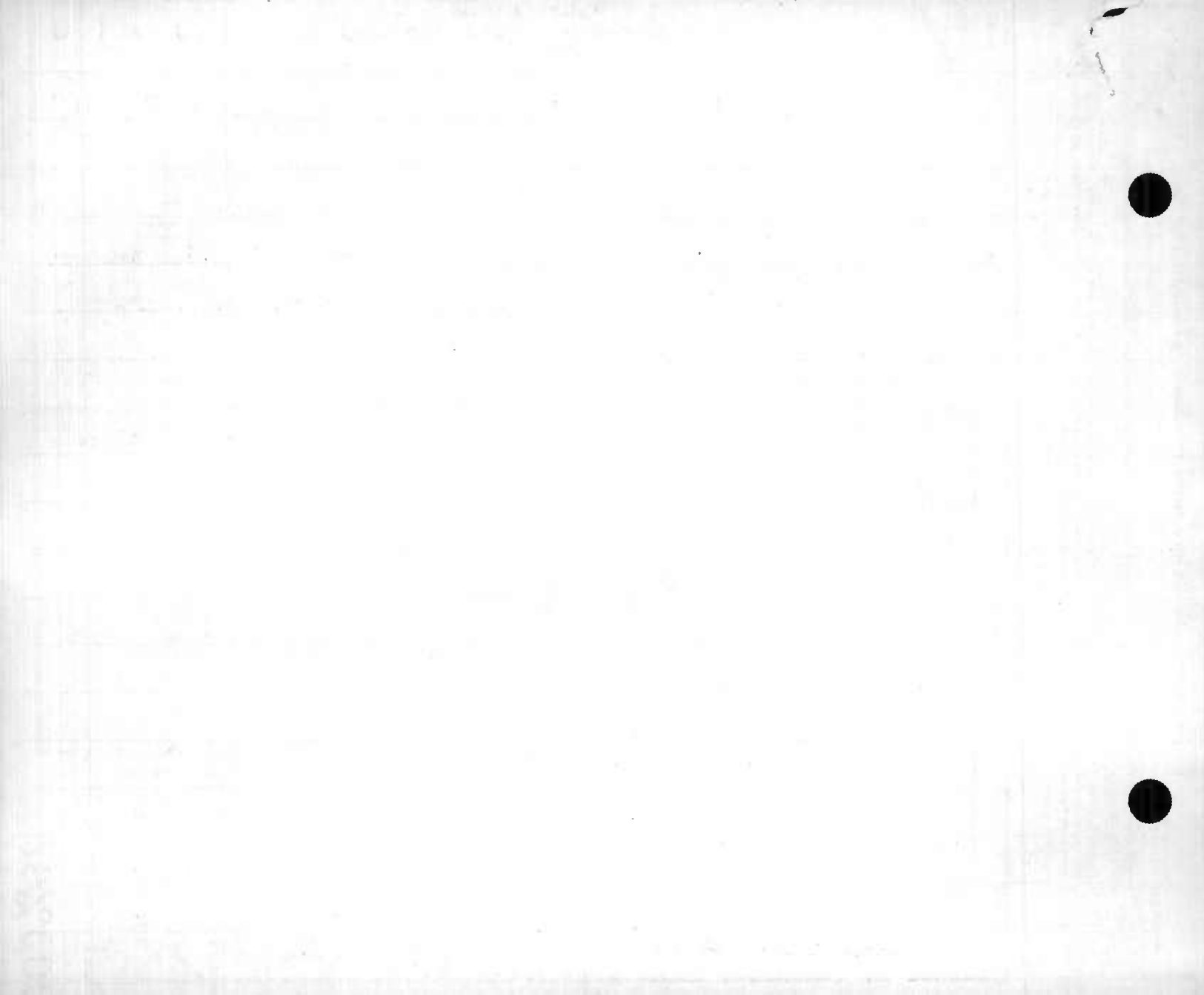
Ref: Postal Carrier

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

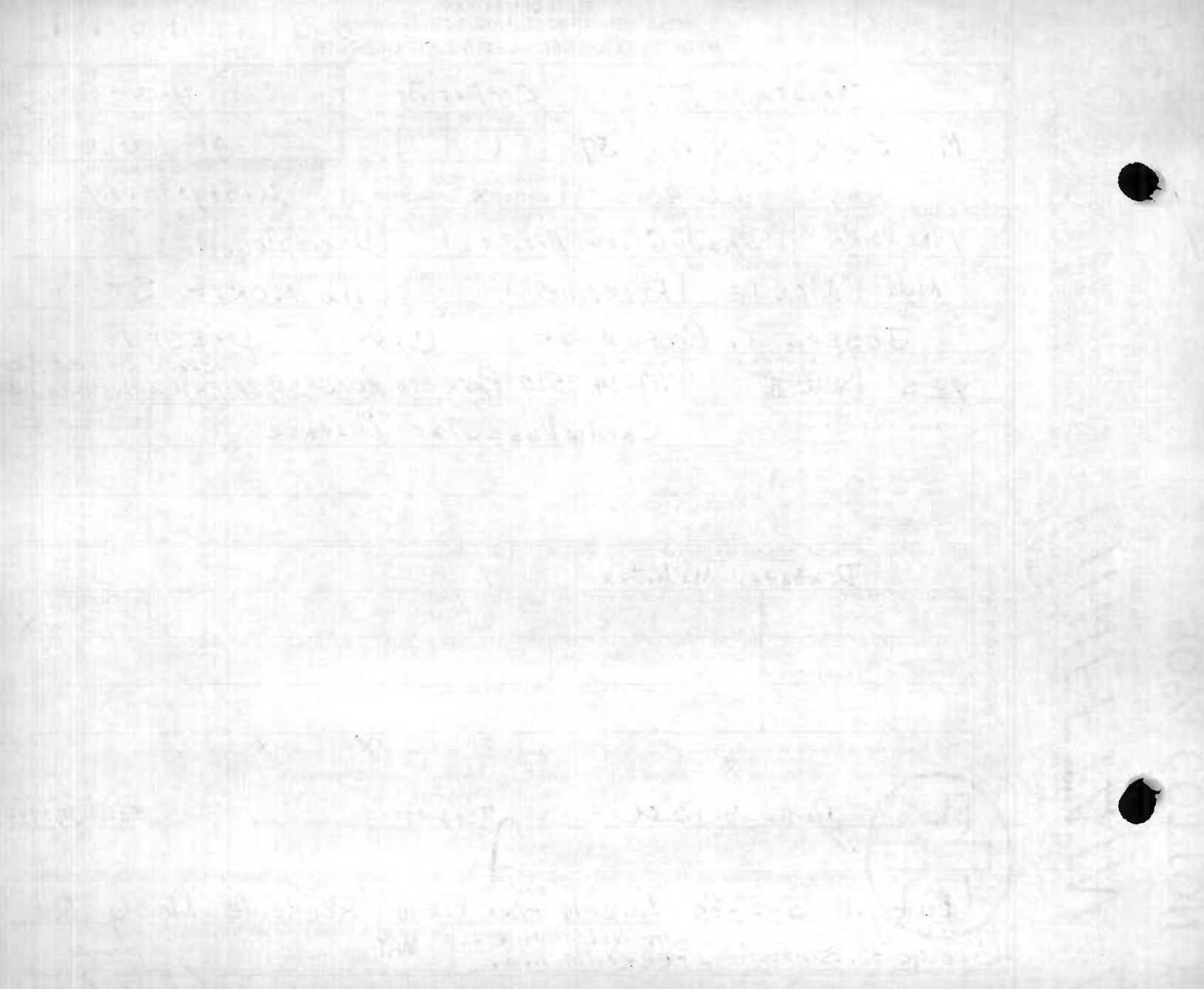
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8010610			
1- FOR STATE REGISTRAR					CERTIFICATE OF DEATH								
1. DECEASED NAME (TYPE OR PRINT)					2r. DATE OF DEATH					2b. HOUR			
FIRST MIDDLE LAST Thomas B Cook					MONTH DAY YEAR April 11 80					11 A M			
3 SEX		4 RACE		5. DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
male		White		MONTH DAY YEAR 10 23 1933			46 YRS		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH				
Wash. D. C. U.S.A.									Montgomery MD.				
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring			Holy Cross						Electrical Eng.		Retired		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13r. STREET ADDRESS							
Md.		Mont.		Wheaton		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		12916 Esteile Road					
14 FATHER'S NAME					15. MOTHER'S MAIDEN NAME								
FIRST MIDDLE LAST Stewart G. Cook					FIRST MIDDLE LAST Margaret King								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17 INFORMANT						
No					577-42-3290		12916 Esteile Rd. Rosemary M. Cook, Wheaton, Maryland						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPTICEMIA										2 WEEKS			
0389													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
CHRONIC RENAL FAILURE, DIABETES MELLITUS													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
							YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
			HOUR A.M. MONTH DAY YEAR P.M. 19										
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION							
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from Feb. 16, 1980, to April 11, 1980, that (I) (we) last saw the deceased alive on April 11, 1980, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.													
22b. SIGNATURE					DEGREE					22c. DATE SIGNED			
Barry Hecht					M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					4/11/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS								
BARRY HECHT					10620 GEORGIA AVENUE SILVER SPRING, MD.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION					
Burial			4/14/80		Gate of Heaven			Silver Spring, Md.					
24 FUNERAL DIRECTOR NAME					24b. ADDRESS					25a. DATE RECD. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Warner E. Pumphrey, Inc.					8434 Ga. Ave. Sil. Spr., Md.					APR 17 1980			



FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Joseph T. Cooper Jr</i>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <i>4-30 1980</i>			2b. HOUR AM PM <i>10:30 AM</i>		
3. SEX <i>M</i>	4. RACE <i>Black</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>2-11-1923</i>	6. AGE (IN YEARS) (LAST BIRTHDAY) <i>57</i> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <i>April 30 1980</i>	2d. HOUR AM PM <i>10:30 AM</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.		
10. CITY OR TOWN OF DEATH <i>Rockville</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Shady Grove Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Unemployed</i>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <i>Md.</i>			13b. COUNTY <i>MONTG</i>	13c. CITY OR TOWN <i>Rockville</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <i>116 NORTH ST</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>JOSEPH T. COOPER, SR.</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>CARRIE DORSEY</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>Yes WWII</i>			16b. SOCIAL SECURITY NO. <i>217-14-7370</i>		17. INFORMANT ADDRESS <i>PATRICIA HOES (DAUGHTER) Gaithersburg, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CardioVascular Disease</i> <i>4292</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <i>Diabetes-Mellitus.</i>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>John S. Ball</i>			TITLE (SPECIFY) <i>Deputy</i>			DATE SIGNED <i>April 30 1980</i>		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>5-3-80</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lincoln Park Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Rockville Montg Md</i>		
24. FUNERAL DIRECTOR NAME <i>George R. Snowden</i>			ADDRESS <i>246 N. WASH. ST. Rockville, Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>MAY 5 1980</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

75
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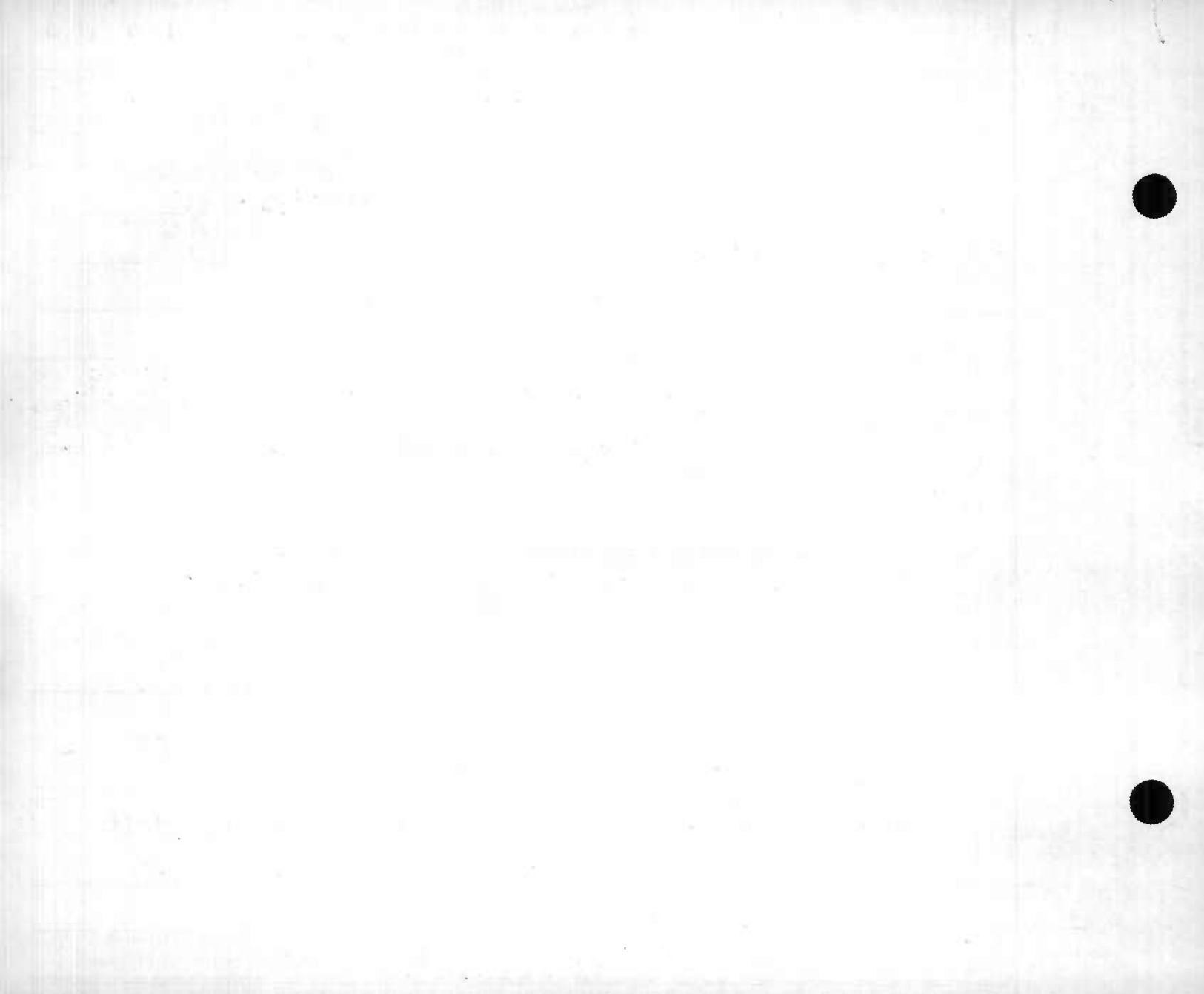
1- FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Ann G. Corless				2a. DATE OF DEATH MONTH DAY YEAR April 5, 80				2b. HOUR 11:39 PM			
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Mar. 17 1912		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (If not in hospital, give street address) 9101 Second Ave Silver Spring				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY own home			
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Sil. Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1914 Luzerne Avenue,	
14. FATHER'S NAME FIRST MIDDLE LAST Matthew J. Reilly				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Walk							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. none		17. INFORMANT (husband) ADDRESS John P. Corless-(same as 13e)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Thrombosis</u> 4340 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Disorder Metabolism</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) —					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Feb 9, 1980, to present, 1980, that (I) (we) lost saw the deceased alive on 4/5/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE John B. Umbau MD				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/6/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John B. Umbau MD				22e. ADDRESS 8805 Conn. Ave. Oak Park Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 4-8-80		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE Sil. Spr. Montgomery Md.			
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. 8434 Ga. Ave., S.S. Md.				DATE REC'D. BY REGISTRAR APR 10 1980				25b. REGISTRAR'S SIGNATURE Ruthy Helms			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		8 0 1 0 6 1 3									
1. DECEASED NAME (TYPE OR PRINT)		FIRST ALEXINA		MIDDLE		LAST COUTURE		2a. DATE OF DEATH MONTH DAY YEAR 4 - 16 - 80		2b. HOUR 4:15 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 18 1894		6. AGE (IN YEARS LAST BIRTHDAY) 86		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 74 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Canada		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN Sil. Spr.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 8703 Milford Avenue			
14. FATHER'S NAME FIRST MIDDLE LAST Arthur Morin				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 037-03-55263		17. INFORMANT Irene C. Bell				ADDRESS 8703 Milford Ave. Silver Spring, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>septicemic shock</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>4370</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>arteriosclerotic cerebrovascular dis. with senility</u> PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>arteriosclerotic cerebrovascular dis. with senility</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>4-16-80</u> to <u>4-16-80</u> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <u>4-16-80</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did not view the body after death.											
22b. SIGNATURE <u>George F. Sengstack M.D.</u>				DEGREE M.D.				22c. DATE SIGNED 4-16-80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George F. Sengstack M.D.				22e. ADDRESS 9241 Columbia Blvd. Sil. Spr., Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/19/80		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE East Providence R. I.					
24. FUNERAL DIRECTOR NAME Warner E. Pumphrey, Inc.		ADDRESS 8434 Ga. Ave. Sil. Spr., Md.		25a. DATE REC'D. BY REGISTRAR APR 21 1980		25b. REGISTRAR'S SIGNATURE <u>Henry McCready</u>					



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR					REG. NO. 8 0 1 0 6 1 4				
1 DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
FIRST MIDDLE LAST					MONTH DAY YEAR				
Hazel H Cowan					April 11, 1980				
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR	
Female		Caucasian		4/20/1913		66 YRS.		3:50 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		10 MONTHS	
Altoona, Pa.		U.S.A.				Montgomery CO MD.			
11 CITY OR TOWN OF DEATH		12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		13a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		14a. KIND OF BUSINESS OR INDUSTRY		15a. WELFARE SER.	
Bethesda		Suburban Hospital		Penn. State Gov.		Welfare Ser.			
16a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					17a. INSIDE CITY LIMITS?				
13a. STATE 13b. COUNTY 13c. CITY OR TOWN					YES <input type="checkbox"/> NO <input type="checkbox"/>				
MD Mont Gaithersburg					9054 Centerway Rd				
14 FATHER'S NAME (FIRST MIDDLE LAST)					15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)				
Harry H. Longnecker					Cora B. Chevalier				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.				
No					173-14-4145				
17 INFORMANT					ADDRESS				
Thomas Cowan					9054 Centerway Road, Gaithersburg, Md. 20760				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic Bronchogenic Carcinoma 1629									
DUE TO, OR AS A CONSEQUENCE OF (b)									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
			P.M. 19						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4/11 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not) view the body after death.									
22b. SIGNATURE					DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED
Stephen Newman, M. D.					MD				4/11/80
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
Stephen Newman, M. D.					19261 Montgomery Village Ave., Gaithersburg, Md. 20760				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial			4/15/80		Calvary Cemetery		Altoona Blair Penn.		
24. FUNERAL DIRECTOR NAME					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Jones Funeral Home					1222 13th Avenue, Altoona, Pa. 16601		APR 15 1980		

MEDICAL CERTIFICATION

99

1

0702 BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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BP

DHMH - 16 50M 7/77
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		20. DATE OF DEATH		MONTH DAY YEAR		21. HOUR A	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		4/4/80		12:05 M	
BERTHA G. CREAMER							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
FEMALE		CAUCASIAN		Aug. 11, 1895		84 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Wash., D.C.		USA				Montgomery MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Rockville		Potomac Valley Nursing Home		Homemaker		Home	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md.		Howard		Clarksville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS			
FIRST MIDDLE LAST		FIRST MIDDLE LAST		12602 Clarksville Pike			
Charles O. Taylor		Mary E. Higgins					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		218-38-9371		Pauline C. Bryan		Same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Respiratory Arrest</u> 4340 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Infarction</u> (c) <u>Cerebral Arterio Thrombosis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		15'		72 hrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
Gen. arteriosclerosis, old Brain Tumor, Atrial Fibrillation						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
		HOUR A.M. MONTH DAY YEAR P.M. 19				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>3/10/80</u> to <u>4/4/80</u> , that (I) (we) last saw the deceased alive on <u>4/3/80</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
		<u>Stephen Jones</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		4/4/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
Stephen Jones, M.D.		809 Viers Mill Rd. Rockville, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		Apr. 8, 1980		Potomac MethChCem.		CITY OR TOWN COUNTY STATE	
						Potomac, Md.	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Robert A. Pumphrey Funeral Homes, P.A. Rockville, Md.		APR 9 1980		<u>Lucy H. H. H.</u>			

2003

152E-62-B15

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR										STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 10616			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST James Herbert CREGER										20. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 4-22-80										21. HOUR AM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 6, 1926		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 54		IF UNDER 1 YR. MONTHS DAYS 0 0		IF UNDER 24 HRS. HOURS MIN. 0 0		21. DATE PRONOUNCED DEAD MONTH DAY YEAR April 22, 1980										22. HOUR 2:30 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co., MD.											
10. CITY OR TOWN OF DEATH Gaithersburg				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 208 Lee St., Apt. 1				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Assembler				12b. KIND OF BUSINESS OR INDUSTRY Manuf.											
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland										13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 208 Lee St., Apt. 1							
14. FATHER'S NAME FIRST MIDDLE LAST Gratien P. Creger										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Willie Sue Ellis													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 224-28-3929				17. INFORMANT ADDRESS 8301 Warfield Rd. Gloria J. Creger, Gaithersburg, Md.															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency Acute 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ Multiple Sclerosis-chronic.																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE John G. Ball				TITLE (SPECIFY) M.D. Deputy				MEDICAL EXAMINER				DATE SIGNED April 22, 1980											
EXAMINER'S NAME (TYPE OR PRINT) John G. Ball, M.D.				ADDRESS Bethesda, Md.																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Apr. 25, 1980		23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon				23d. LOCATION CITY OR TOWN COUNTY STATE Damascus, Montgomery, Md.													
24. FUNERAL DIRECTOR NAME Olin L. Molesworth, Damascus, Md.										25a. DATE REC'D. BY REGISTRAR APR 28 1980		25b. REGISTRAR'S SIGNATURE Henry McCready											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 (if retained by the hospital or attending physician).

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|---|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | 7. REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) WALLACE James Crisp | | | | | 2a. DATE OF DEATH MONTH DAY YEAR April 15, 1980 | | | 2b. HOUR 3:30 PM | |
| 3 SEX Male | | 4 RACE Caucasian | | 5 DATE OF BIRTH MONTH DAY YEAR March 17, 1923 | | 6 AGE (IN YEARS LAST BIRTHDAY) 57 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD. | | | |
| 10 CITY OR TOWN OF DEATH Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Security Guard | | 12b. KIND OF BUSINESS OR INDUSTRY Giant Food | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Rockville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 4725 Wyaconda Road | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Riley Crisp | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Buckner | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. WW 11 242-18-1190 | | 17 INFORMANT ADDRESS Elverne R. Crisp, Same as 13 | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Cardiac arrest - Ventricular Fibrillation | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hrs | |
| 410-
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Acute Myocardial Infarction | | | | | | | | 8 hrs. | |
| (c) Coronary atherosclerosis | | | | | | | | 10 yrs | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Diabetes Mellitus, Pulmonary Edema | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 P.M. | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/15/80 to 4/15/80 , that (I) (we) last saw the deceased alive on 4/15/80 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Stephen N. Jones | | | | | DEGREE | | | 22c. DATE SIGNED 4/15/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen N. Jones | | | | | 22e. ADDRESS 809 Viers Mill Road Rockville, MD 20850 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 4-18-80 | | 23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland | |
| 24 FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY | | | | | 25a. DATE REC'D. BY REGISTRAR APR 22 1980 | | | | |
| 24 HOMES, P. A., Rockville, Maryland | | | | | 25b. REGISTRAR'S SIGNATURE Harvey McCready | | | | |

JONES, R. A., Rockville, Maryland
 ROBERT A. JONES-FURNAL
 4-18-80 Baltimore Memorial Park Rockville, Maryland
 Burial

Stephen L. Jones
 Rockville, MD 20850
 809 Viers Hill Road

Yes
 Mt. II
 242-18-1190 Elvorne R. Crisp, Same as 13

Rife
 Maryland
 Montgomery
 Rockville
 Crisp
 Estate
 Buckner

Bethesda
 Suburban Hospital
 Security Guard - State Food

North Carolina
 U. S. A.
 Caucasian
 March 17, 1923
 Montgomery County

April 12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | 8 0 1 0 6 1 8 | | | | |
|--|--|--|--|--|--|---|---|---|--|
| FOR
1- STATE
REGISTRAR | | | | | REG. NO. | | | | |
| 1 DECEASED NAME
(TYPE OR PRINT)
Louise Ione Crosby | | | | | 2a DATE OF DEATH
MONTH DAY YEAR
April 22, 1980 | | | 2b HOUR
P
6:05 | |
| 3 SEX
Female | | 4 RACE
White | | 5 DATE OF BIRTH
MONTH DAY YEAR
April 6, 1913 | | 6 AGE (IN YEARS LAST BIRTHDAY)
67 YRS | | 7 IF UNDER 1 YEAR
MONTHS DAYS | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WEST VIRGINIA | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | |
| 10 CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Clinical Center, Bethesda, MD | | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY
AT HOME | |
| 13a STATE
Maryland | | 13b COUNTY
MONTG. | | 13c CITY OR TOWN
Bethesda | | 13d INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS
5103 Wissioming Rd. 20016 | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
NELSON B. COOPER | | | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
JULIA WILSON | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b SOCIAL SECURITY NO
(IF YES, GIVE WAR OR DATES)
578-01-0027 | | 17 INFORMANT ADDRESS
Mr. Beverly Crosby, Husband above | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sepsis
4240
DUE TO, OR AS A CONSEQUENCE OF (b) Mediastinitis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }
DUE TO, OR AS A CONSEQUENCE OF (c) Mitral Valve Replacement | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 days
4 months
4 months |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
none | | | | | | | | | |
| 19a DATE OF OPERATION
12/18/79 | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED
Mitral Regurgitation | | | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 16, 1979, to April 22, 1980, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 22, 1980, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.) | | | | | | | | | |
| 22b. SIGNATURE
Steven R. Gundry MD | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
4/23/80 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Steven R. Gundry MD | | | | | 22e. ADDRESS
National Institutes of Health
Clinical Center, Bethesda, Md. 20203 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
4-25-80 | | 23c. NAME OF CEMETERY OR CREMATORY
PARKLAWN CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ROCKVILLE MONTG. MD. | | | |
| 24 FUNERAL HOME
JOSEPH GAWLER'S SONS INC
NAME ADDRESS
1121 WIS. AVE., N. W. WASH., D. C. 20016 | | | | | 25a. DATE REC'D. BY REGISTRAR
APR 28 1980 | | 25b. REGISTRAR'S SIGNATURE
Lefroy McCreedy | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

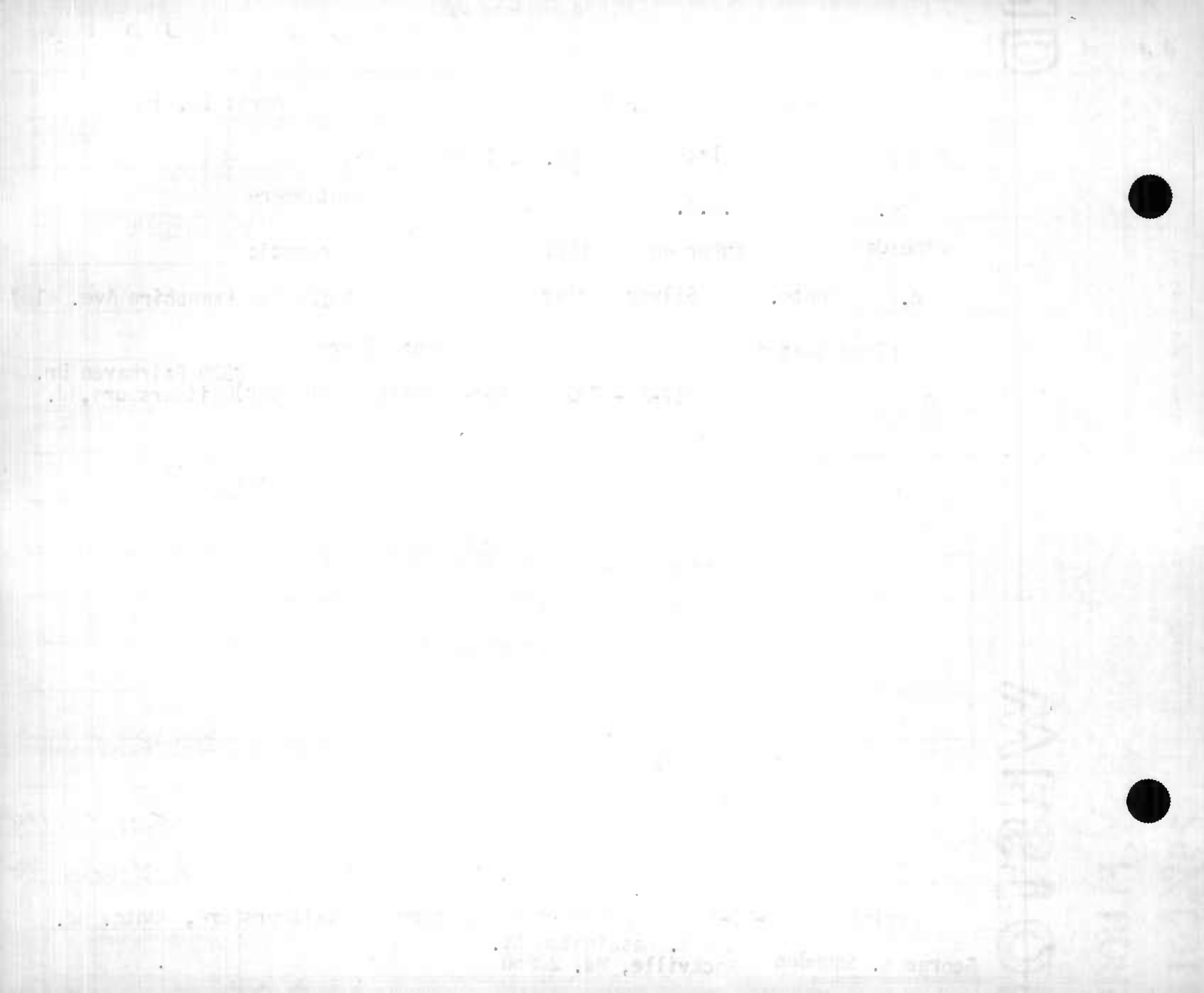
FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 1 0 6 1 9

REG. NO.

| | | | | | | | | | |
|---|--|--|---|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Belle Curtis | | | 2a. DATE OF DEATH
MONTH DAY YEAR
April 14, 1980 | | | 2b. HOUR
M | | | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
Feb. 5, 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY)
80 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Domestic | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md. | | 13b. CITY OR TOWN
Montg. | | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS
10120 New Hampshire Ave. #107 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Lloyd Coates | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Annie Terry | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO
(IF YES, GIVE WAR OR DATES)
217-32-2793 | | 17. INFORMANT ADDRESS
8329 Fairhaven Dr.
Laverne Bailey (Daughter) Gaithersburg, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coma</u>
2502
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) <u>Diabetes Mellitus</u>
(c) <u>Hypertension</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>April 12, 1980</u> to <u>April 12, 1980</u> , that (I) (we) last saw the deceased alive on <u>April 12, 1980</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Boo K. Kim</u> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
April 14, 1980 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Boo K. Kim | | | | 22e. ADDRESS
16220 Frederick Rd. Gaithersburg, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
4-17-80 | | 23c. NAME OF CEMETERY OR CREMATORY
Emory Grove Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Gaithersburg, Montg. Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
George R. Snowden | | | | 24b. ADDRESS
246 N. Washington St.
Rockville, Md. 20850 | | 25. DATE REC'D BY REGISTRAR
APR 17 1980 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 7. REG. NO. | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
JAMES CLEMENS DAEBLER | | | | 2a. DATE OF DEATH
APRIL 04 1980 | | 2b. HOUR
8:50P M | | | |
| 3. SEX
MALE | | 4. RACE
CAUCASION | | 5. DATE OF BIRTH
JUNE 29 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY)
70 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEW JERSEY | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NAVAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY
Military | |
| 13a. STATE
NEW JERSEY | | 13b. CITY OR TOWN
CAPE MAY | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS
BOX 166 Shore Road | | | |
| 14. FATHER'S NAME
John W. Daebler | | | | 15. MOTHER'S MAIDEN NAME
Emma Fisher | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE YEAR OR DATES)
WWII 068 24 8286 | | 17. INFORMANT ADDRESS
James C. Daebler, Jr. same as item 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) METASTATIC LUNG CARCINOMA
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 26 MARCH 19 80, to 04 APRIL 19 80, that (I) (we) last saw the deceased alive on 04 APRIL 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
J.K. O'DONNELL | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
4-5-80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
J.K. O'DONNELL | | | | 22e. ADDRESS
Bethesda, Maryland
National Naval Medical Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
4/10/80 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arlington, Virginia | | | |
| 24. FUNERAL DIRECTOR NAME
Robert A. Pumphaey Funeral Homes, P.A. Bethesda, Maryland | | | | 25. DATE REC'D BY REGISTRAR
APR 14 1980 | | 25b. REGISTRAR'S SIGNATURE | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR
1- STATE
REGISTRAR | | | | | | | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | | | | | | | | | | | |
|---|--|---------|--|--|--|-------------------|--|---|--|--|--|--------------------------------------|--|----------|--|-----------------------------------|--|--|--|---|--|----------|--|--|--|--|--|--|--|---------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | | | | | | | FIRST MIDDLE LAST | | | | | | | | | | 20. DATE KNOWN OF DEATH | | 26. HOUR | | | | | | | | | |
| Blanche N. Dalton | | | | | | | | | | | | | | | | | | | | April 1 1980 | | 338 | | | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 21. DATE PRONOUNCED DEAD | | 26. HOUR | | | | | | | | | | | | | | | | | |
| F | | W | | Oct 12 1957 | | 4 YRS. | | MONTHS | | DAYS | | HOURS | | MIN. | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | | | | | | | | | |
| Leesburg, Va. | | | | U. S. A. | | | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | Montgomery MD. | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | |
| S. & Spg | | | | 13000 Hatheway Dr | | | | | | | | House Wife. | | | | | | | | | | | | | | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | 13a. INSIDE CITY LIMITS? | | | | | | | | | | 13b. STREET ADDRESS | | | | | | | | | | | |
| 13a. STATE | | | | | | | | | | 13b. COUNTY | | | | | | | | | | 13c. CITY OR TOWN | | | | | | | | | | | |
| Md | | | | | | | | | | Montg | | | | | | | | | | S. & Spg | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | | | |
| Samuel McGill Nixon. | | | | | | | | | | Frances Mathers. | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | | | | | 17. INFORMANT | | | | | | | | | | | |
| No. | | | | | | | | | | 577-01-92598 | | | | | | | | | | Miles W. Dalton. 13 e. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Acute Myocardial Infarction | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? | | | | | | | | | | | |
| None | | | | | | | | | | | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | | | | | 21b. TIME OF INJURY | | | | | | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| | | | | | | | | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | | | | | | 21f. LOCATION | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on | | | | | | | | | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | | | | | |
| death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | | | | | | | TITLE (SPECIFY) | | | | | | | | | | DATE SIGNED | | | | | | | | | | | |
| EXAMINER'S NAME | | | | | | | | | | MEDICAL EXAMINER | | | | | | | | | | April 1 1980 | | | | | | | | | | | |
| (TYPE OR PRINT) | | | | | | | | | | ADDRESS | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | | | | | | 23b. DATE | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | | 23d. LOCATION | |
| Burial | | | | | | | | | | | | | | | | | | | | Takoma Cedar Hill Cemetery, Suitland Rd. P. Geo. Md. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| J. Arthur Walters | | | | | | | | | | W. APR 23 1980 | | | | | | | | | | Fitzroy McCreedy | | | | | | | | | | | |

Matthews

Francis

Samuel Moffitt Nixon

507-01-2222 Miss J. Wilson, 112 a.

RECEIVED
JAN 10 1964

RECEIVED
JAN 10 1964
Miss J. Wilson, 112 a.
507-01-2222

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

80 10622

REG. NO.

| | | | | | |
|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) BEULAH ELEANORA DANIELS | | | 2a. DATE OF DEATH
MONTH DAY YEAR 4/17/80 | | 2b. HOUR
7:05 PM |
| 3 SEX
Female | 4 RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR Apr. 6 1908 | | 6 AGE (IN YEARS LAST BIRTHDAY)
72 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington, DC | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | |
| 10 CITY OR TOWN OF DEATH
Takoma Park | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hosp. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | 12b. KIND OF BUSINESS OR INDUSTRY
Montg. Co. School Bd. | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland | | | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Silver Spr. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Andrew H. Tenley | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Beulah Maddox | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
none | | 17 INFORMANT (husband) ADDRESS
William H. Daniels- (same as 13e) | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) acute myeloblastic leukemia
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
2050
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (in this hospital) attended the deceased from 4/11 19 80 , to 4/17 19 80 , that (we) lost 0 saw the deceased alive at 0445 19 80 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We) did (did not) see the body after death. | | | | | |
| 22b. SIGNATURE
Lewis H. Dennis | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
4/17/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Lewis H. Dennis, MD. | | 22e. ADDRESS
831 Univ., Blvd., E. S.S. Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
4-21-80 | 23c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood Pr. Georges Md. |
| 24. FUNERAL DIRECTOR
Warner E. Pumphrey, Inc. | | 24a. DATE REC'D. BY REGISTRAR
APR 22 1980 | | 24b. REGISTRAR'S SIGNATURE
[Signature] | |
| 24c. ADDRESS
8434 Ga. Ave., S.S. Md. | | | | | |

South of the Lake

1912
1913

Chas. H. H.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8010623

REG. NO.

| | | | | | | | | | |
|---|--|---|--|--|--|---|--|---|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
LILLIAN ELIZABETH DAVIS | | | 2a. DATE OF DEATH MONTH DAY YEAR
4-24-80 | | | 2b. HOUR
5⁰⁰ AM | | | |
| 3 SEX
Female | | 4 RACE
Negro | | 5 DATE OF BIRTH
MONTH DAY YEAR
MAY 23 1918 | | 6 AGE (IN YEARS LAST BIRTHDAY)
61 | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
md | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10 CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Custodian | | 12b. KIND OF BUSINESS OR INDUSTRY
Fed Gov | |
| 13a. USUAL RESIDENCE
13b. STATE
md | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Gaithersburg | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
415 West Diamond Ave | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Charles William DAVIS | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Edith Lillian Hill | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
579-20-2674 | | 17 INFORMANT
Brenda Squirrel 415 W. Diamond Ave | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Gram negative Septicemia
2639
DUE TO, OR AS A CONSEQUENCE OF
(b) Cellulitis & osteomyelitis
DUE TO, OR AS A CONSEQUENCE OF
(c) Granulation | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
one month
3 months
years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).
Intracranial hemorrhage | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 25 19 79 , to April 24 19 80 , that (II) (we) last saw the deceased alive on April 23 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Martin C. Shargel | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
4/24/80 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MARTIN C. SHARGEL M.D. | | 22e. ADDRESS
3720 FARRAGUT AVE.
KENSINGTON MD-20795 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
4-28-1980 | | 23c. NAME OF CEMETERY OR CREMATORY
Barlonsville | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Barlonsville Fred md | | | |
| 24 FUNERAL DIRECTOR
NAME
C.E. Hill III | | | | ADDRESS
263 W. Patrick St Fred. md | | 25a. DATE REC'D. BY REGISTRAR
APR 29 1980 | | 25b. REGISTRAR'S SIGNATURE
Pietro McCreedy | |

10

Lillian Alice Davis

4-24-30

May 23 1918

Formal Report

X Montgomery

and N.D.P.

Since 1900, the first of the series of reports

has been published by the U.S. National

Geographic Names Board, which

has been established by the U.S. Government

for the purpose of

collecting and

publishing

the names of

places in

the United

States and

its

possessions

and

territories

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH-16 25M
(VRA 15, 4) 1/79

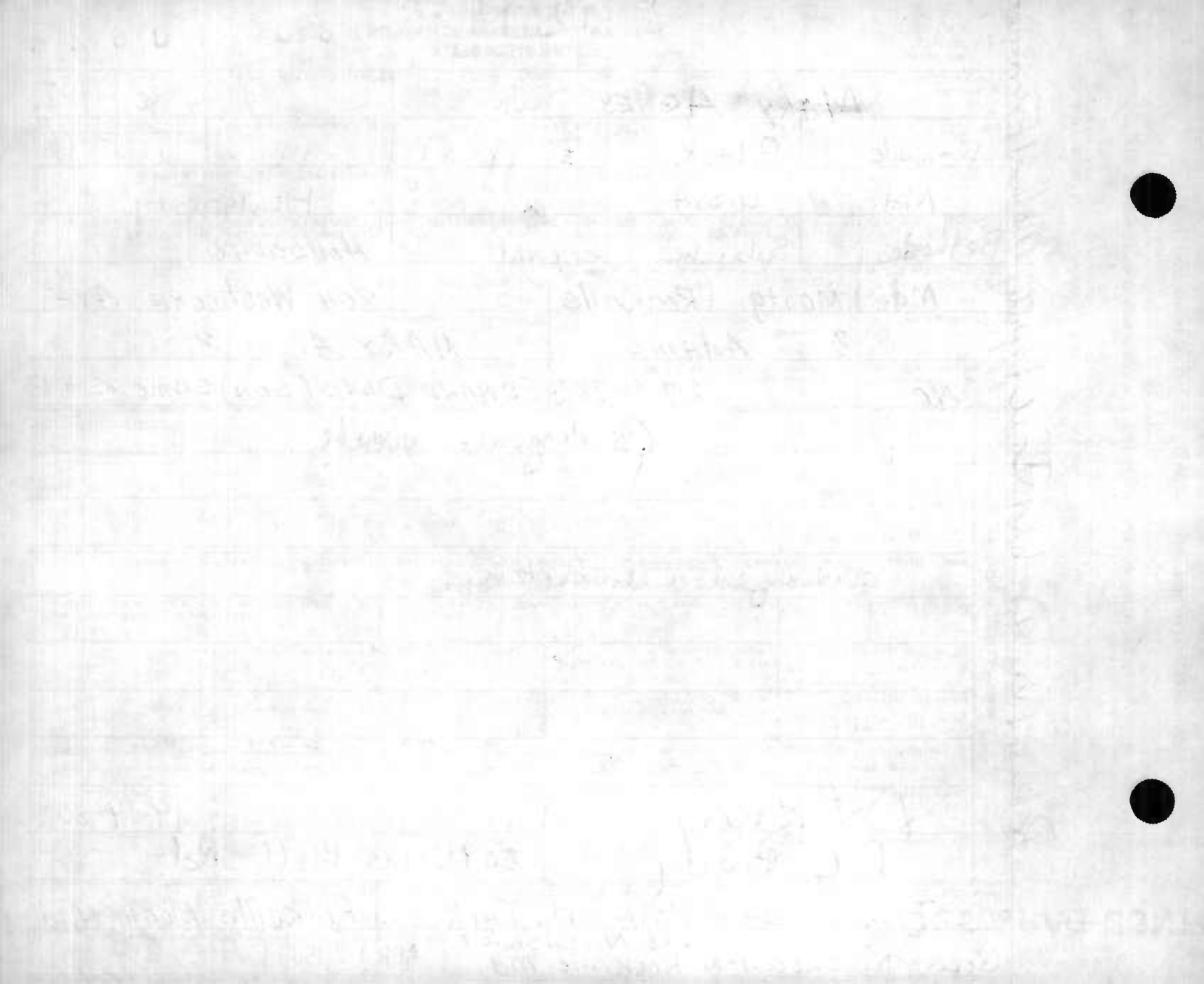
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is checked or item 30 shows any injury or other condition, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8010624 | | | |
|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) MARY AGNES Davis | | | | 2a. DATE OF DEATH MONTH DAY YEAR 4 14 80 | | 2b. HOUR 1:35 AM | |
| 3. SEX Female | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 3 18 81 | | 6. AGE (IN YEARS LAST BIRTHDAY) 99 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md. | | 13b. COUNTY Montg. | | 13c. CITY OR TOWN Rockville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST ? MIDDLE Adams LAST Adams | | 15. MOTHER'S MAIDEN NAME FIRST MARY A. MIDDLE ? LAST ? | | 16. SOCIAL SECURITY NO 217-32-3893 | | | |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 17b. SOCIAL SECURITY NO 217-32-3893 | | 17. INFORMANT ADDRESS EDWARD DAVIS (SON) SAME AS #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronogenic shock
4409
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) generalized arteriosclerosis | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 P.M. | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4-13-80 to 4-14-80 , that (I) (we) last saw the deceased alive on 4-13-80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | |
| 23a. SIGNATURE D.C. Bucy | | | | DEGREE M.D. | | 23c. DATE SIGNED 4-14-80 | |
| 23b. PHYSICIAN'S NAME (TYPE OR PRINT) D.C. Bucy | | | | 23d. ADDRESS 809 Ureias Mill Rd. | | | |
| 23e. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23f. DATE 4-18-80 | | 23g. NAME OF CEMETERY OR CREMATORY Lincoln Park Cem. | | 23h. LOCATION CITY OR TOWN COUNTY STATE Rockville Montg Md. | |
| 24. FUNERAL DIRECTOR NAME George R. Snowden | | | | 24b. ADDRESS 244 N. Wash. St. Rockville, Md. | | 25a. DATE REC'D. BY REGISTRAR APR 17 1980 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Arthur McCreedy | | | |

1207 BP



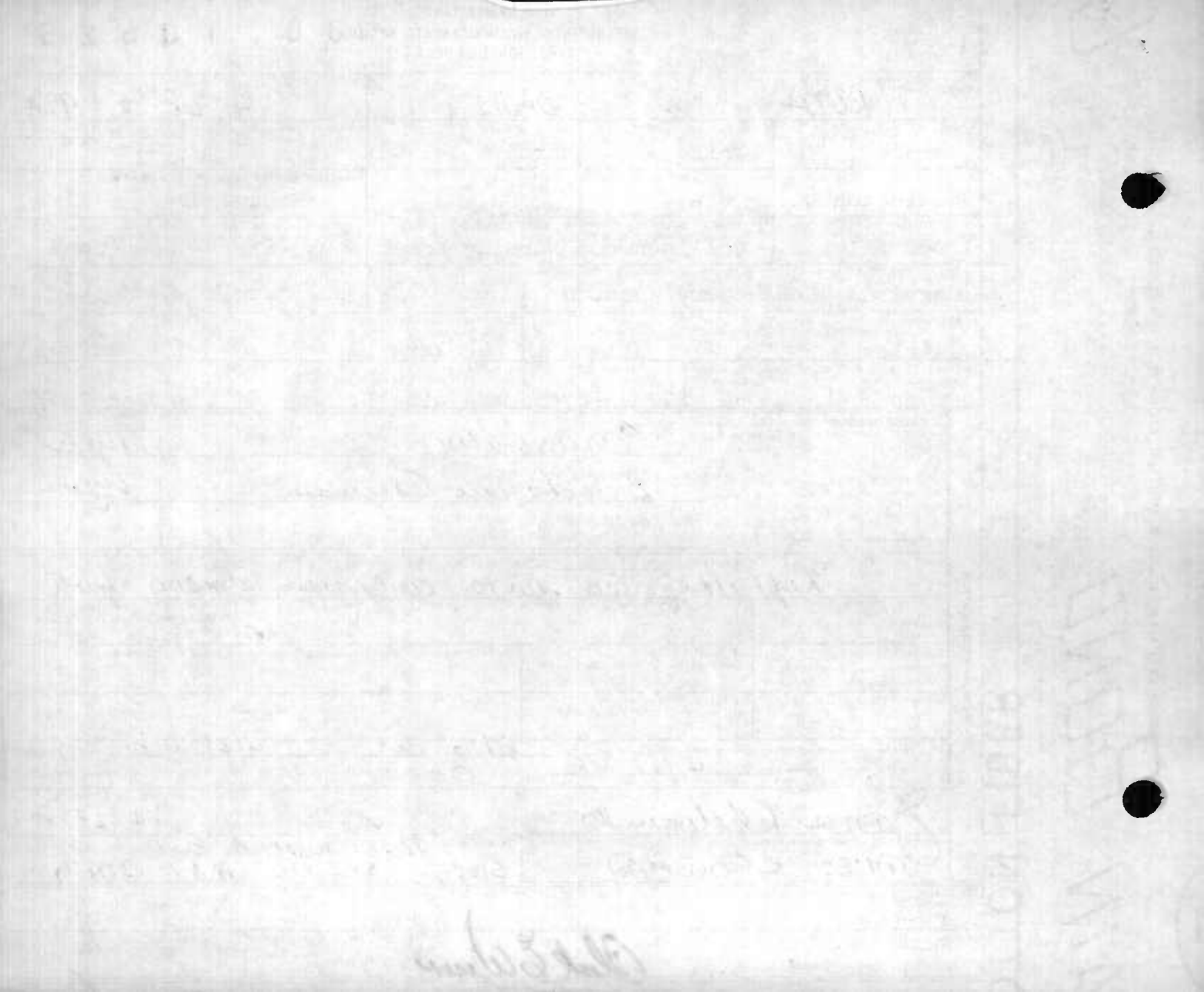
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called and item 18 completed.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | 8 0 1 0 6 2 5 | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) | | | | | 2a DATE OF DEATH | | | | |
| RUTH H. DAVIS | | | | | 4-28-80 9:00 A.M. | | | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | 7b HOUR | |
| Female | | White | | March 8 1901 | | 79 | | 9:00 A.M. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | 10b KIND OF BUSINESS OR INDUSTRY | |
| Washington, DC | | USA | | | | Montgomery | | own home | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| Rockville | | Collingswood Nursing Home | | Housewife | | | | | |
| 13a STATE | | | | | 13b CITY OR TOWN | | | | |
| Maryland | | | | | Montgomery Wheaton | | | | |
| 14 FATHER'S NAME | | | | | 15 MOTHER'S MAIDEN NAME | | | | |
| Charles W. Holmes | | | | | Clara Knight | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b SOCIAL SECURITY NO | | | | |
| no | | | | | none 577-46-0765 | | | | |
| 17 INFORMANT (daughter) | | | | | ADDRESS | | | | |
| Madeleine L. Martin- | | | | | (same as 13e) | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY | | | | | | | | | |
| IMMEDIATE CAUSE (a) <i>Carcinoma</i> | | | | | | | | | |
| 1629 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| (b) <i>Bronchogenic Carcinoma</i> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| <i>Left Hemisphere due to Cerebrovascular Thrombosis remote</i> | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY | | 21c HOW INJURY OCCURRED | | (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | |
| 21d INJURY OCCURRED | | 21e PLACE OF INJURY | | 21f LOCATION | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | STREET | | CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <i>8/16 1963</i> to <i>4/28 1980</i> , that (II) (we) lost saw the deceased above <i>4/28 1980</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE | | | | | 22c DATE SIGNED | | | | |
| <i>James R Coleman MD</i> | | | | | 4-28-80 | | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e ADDRESS | | | | |
| JAMES R COLEMAN | | | | | 9241 COLUMBIA BLD. SILVER SPRING MD. 20910 | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION | | 23e REGISTRAR'S SIGNATURE | |
| Burial | | May 1, 1980 | | Arlington National | | Arlington Va. | | | |
| 24 FUNERAL DIRECTOR | | | | | | | | | |
| Warner E. Pumphrey, Inc. 8434 Ga. Ave., S.S. Md. | | | | | | | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|--|--|---|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) ADELENE M DAVY | | | 2a. DATE OF DEATH
MONTH 4 DAY 3 YEAR 80 | | | 2b. HOUR
4:08 A.M. | | | | | |
| 3. SEX
Female. | | 4. RACE
White. | | 5. DATE OF BIRTH
MONTH Feb. DAY 8 YEAR 1919 | | 6. AGE (IN YEARS LAST BIRTHDAY)
61 YRS | | IF UNDER 1 YEAR
MONTHS DAYS | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Grafton, West Virginia, USA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery. MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hospital. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
House Wife. | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
Maryland. | | | | 13b. COUNTY
Montgomery. | | 13c. CITY OR TOWN
Rockville. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
4815 Topping Rd. | |
| 14. FATHER'S NAME
FIRST Not Available MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME
FIRST Not Available MIDDLE LAST | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No. | | 16b. SOCIAL SECURITY NO.
234-44-1777 | | 17. INFORMANT
Jesse Davy (Husband) | | | | ADDRESS
(13 e) | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST
4240
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) LOW CARDIAC OUTPUT
(c) RE VENTRICULAR FAILURE | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1
Post Mitral ATRICUSPID VALVE REPLACEMENT For Mitral ATRICUSPID REGURITATION | | | | | | | | | | | |
| 19a. DATE OF OPERATION
4/2/80 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
INFECTED PROSTHESIS - MITRAL REGURITATION | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JAN. 19 80 to 4/3 19 80 , that (I) (we) last saw the deceased alive on 4/3 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
A. Neimat, M.D. | | | | DEGREE
M.D. | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
4/3/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
S. NEIMAT, M.D. | | | | 22e. ADDRESS
831 UNIVERSITY Blvd E / SILVER SPRING, MD, 20903 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial. | | 23b. DATE
4/1/80 | | 23c. NAME OF CEMETERY OR CREMATORY
Bluemont Cemetery. | | | | 23d. LOCATION
CITY OR TOWN Grafton, West Virginia. COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR
L. Arthur Walter | | | | 25a. DATE REC'D. BY REGISTRAR
APR 8 1980 | | | | 25b. REGISTRAR'S SIGNATURE
Anthony McCreedy | | | |

BP

Female.

White.

Prof. 1910

BA

Gratton, East Virginia, 1910

London, 1910

Robertson, East Virginia, 1910

London, 1910

Not Available

Not Available

334-44-1777 James Day (London) (11 5)

No.

4/23

Burial.

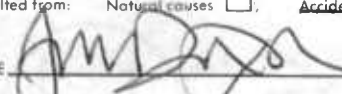
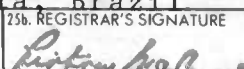
1910

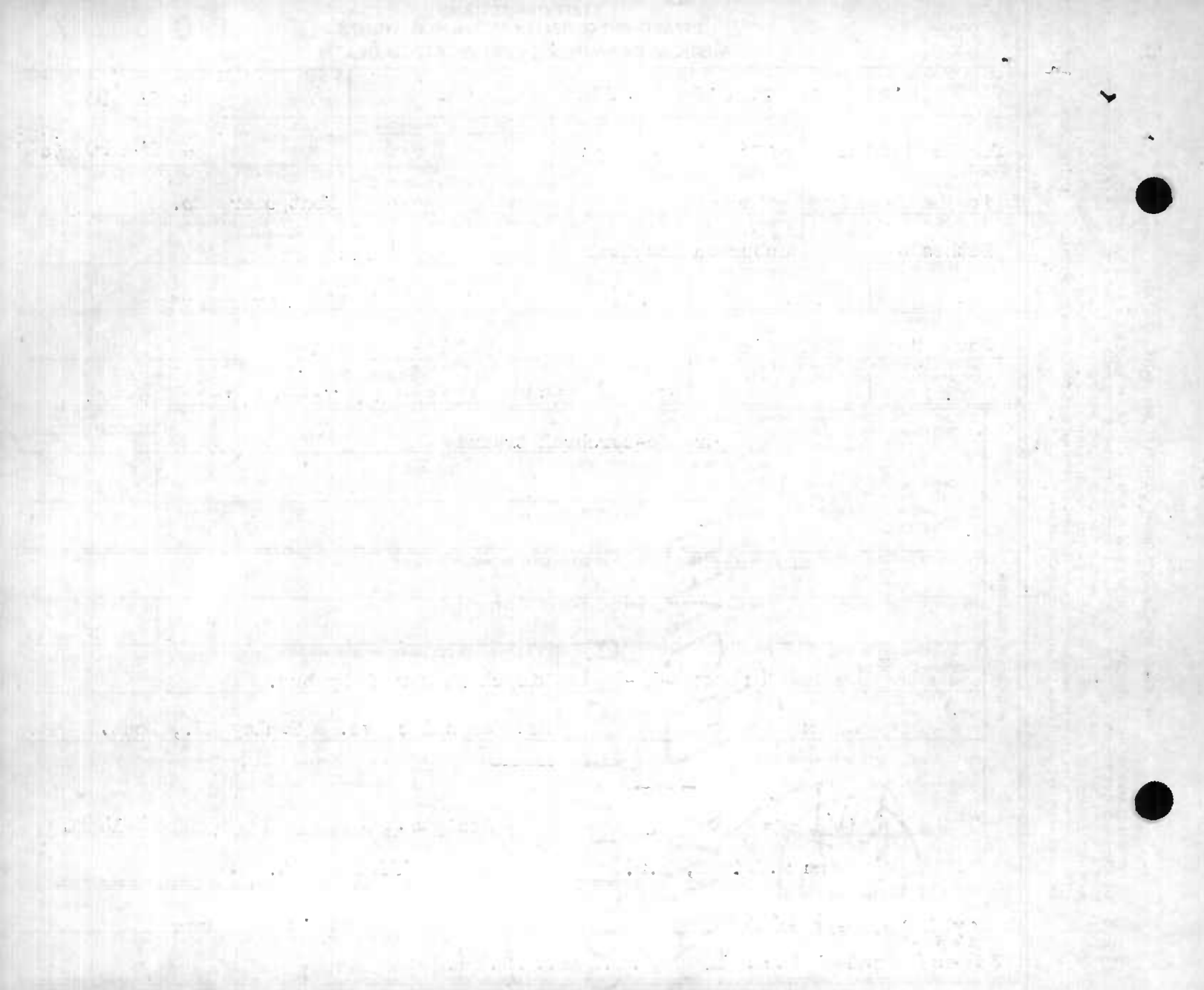
London, 1910

Gratton, East Virginia, 1910

1910

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS FORESEEN, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL REGISTRAR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

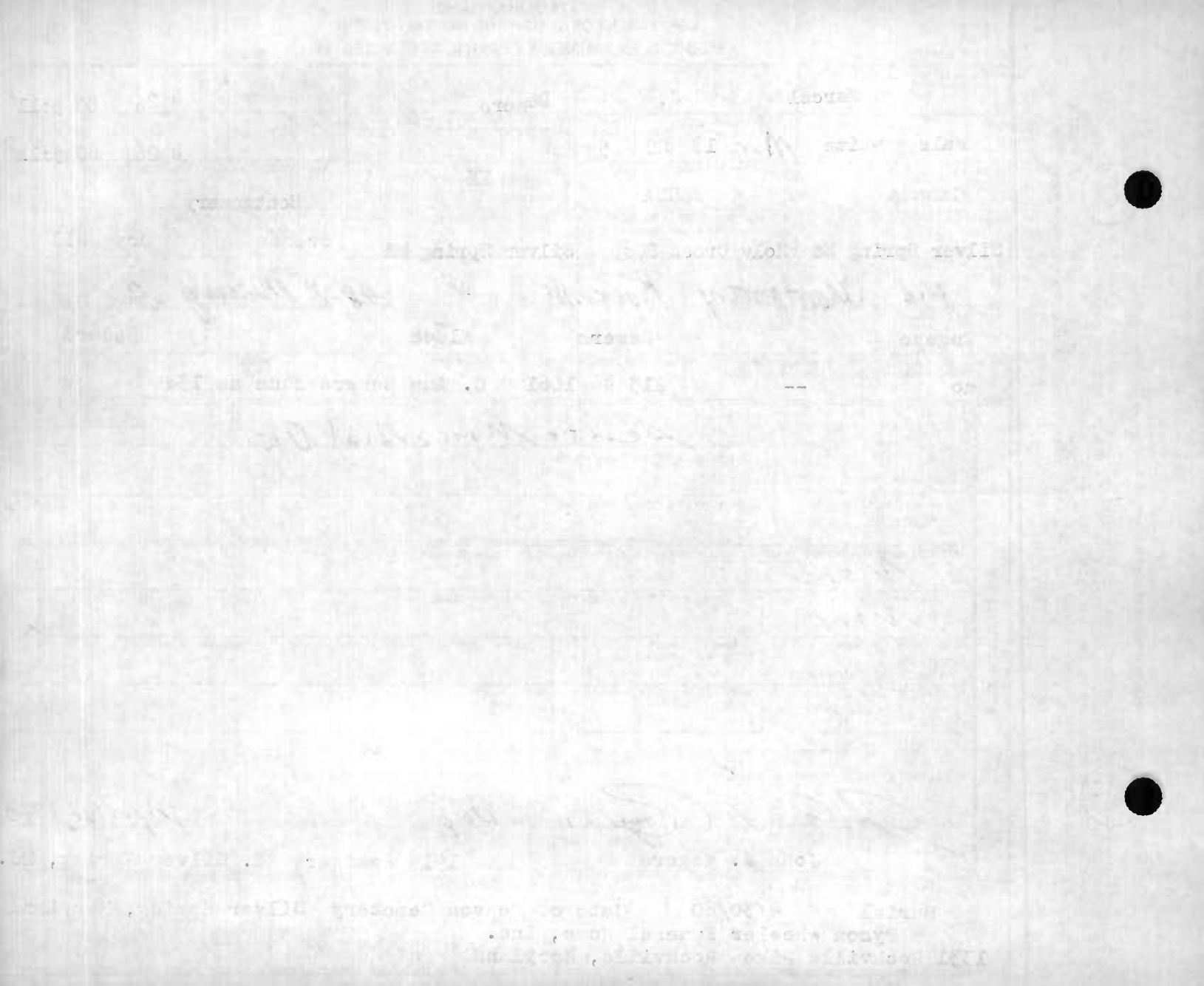
| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 10627 | | | |
|--|--|------------------|--|---|--|---|--|---|--|--|--|--------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) MARIA das GRACAS PEREIRA DELGADO | | | | | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> 4 18 1980 | | 2b. HOUR
M 9:06 | |
| 3. SEX
female | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR 4 14 57 | | 6. AGE (IN YEARS)
(LAST BIRTHDAY) 23 YRS. | | IF UNDER 1 YR.
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Rio de Janeiro | | | | 7b. CITIZEN OF WHAT COUNTRY?
Brazil | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery Co. MD. | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Student | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Md. | | | | 13b. COUNTY
Mont. | | 13c. CITY OR TOWN
S.S. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
12503 Davan Drive | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST Jose Neves. Delgado | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST Zuleika Pereira | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) None | | | | 16b. SOCIAL SECURITY NO.
212 84 5134 | | 17. INFORMANT Same as above
William H. Hoover, Jr. Legal Guardian | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cranio-cerebral trauma</u>
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR 8:10 AM 4-18-1980 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
Bicyclist struck by bus. | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
road | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
New Hampshire Ave. & Tanley Rd., Mont. Md. | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE  | | | | TITLE (SPECIFY)
M.D. Assistant | | | | DATE SIGNED 4/18/80 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | | | ADDRESS 111 Penn St. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | | | 23b. DATE 4/26/80 | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brazilia, Brazil | | | |
| FUNERAL DIRECTOR NAME Hines/Rinaldi F.H. | | | | ADDRESS 11800 N.H. Ave. S.S. Md. | | | | 25a. DATE REC'D. BY REGISTRAR APR 22 1980 | | 25b. REGISTRAR'S SIGNATURE  | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 15 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 10628 | |
|--|--|------------------|--|---|--|---|--|--|---|---|--|
| 1- STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Marcel J. Demers | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR
4 26 19 80 | |
| 3. SEX
male | | 4. RACE
white | | 5. DATE OF BIRTH MONTH DAY YEAR
Mar. 18 22 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS
58 YRS. | | IF UNDER 24 HRS. HOURS MIN. | | 2b. DATE PRONOUNCED DEAD MONTH DAY YEAR
4 26 19 80 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Canada | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring Md | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hosp Silver Spring Md | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Foreman | | 12b. KIND OF BUSINESS OR INDUSTRY
Dry Wall | |
| 13a. STATE
Md. | | | | | | | | | | | |
| 13b. COUNTY
Montgomery | | | | | | | | | | | |
| 13c. CITY OR TOWN
Rockville | | | | | | | | | | | |
| 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 13e. STREET ADDRESS
4808 Murray Dr | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Eugene Demers | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Aldea Bedard | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)
no | | | | 16b. SOCIAL SECURITY NO.
215 46 1661 | | | | 17. INFORMANT ADDRESS
C. Ann Demers same as 13e | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Myocardial Inf.</u>
4291 } DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) } DUE TO, OR AS A CONSEQUENCE OF
(c) } | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).
<u>None</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION
<u>None</u> | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE
<u>John S. Rogers</u> | | | | TITLE (SPECIFY)
M.D. Dep. | | | | DATE
Apr. 126, 1980 | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
John S. Rogers | | | | ADDRESS
1919 Seminary Rd. Silver Spring, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
4/30/80 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Silver Spring, Maryland | |
| 24. FUNERAL DIRECTOR NAME
Tyson Wheeler Funeral Home, Inc.
1331 Rockville Pike Rockville, Maryland | | | | | | 25a. DATE REC'D. BY REGISTRAR
APR 30 1980 | | | 25b. REGISTRAR'S SIGNATURE
<u>Jeffrey M. Brady</u> | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 0 1 0 6 2 9 | | | |
|--|--|---|--|--|--|---|--|
| FOR
STATE
REGISTRAR | | | | CERTIFICATE OF DEATH | | | |
| REG. NO. | | | | | | | |
| 1 DECEASED NAME
(TYPE OR PRINT) Hamaz Der Manuelian | | | | 2a DATE OF DEATH
MONTH DAY YEAR
4/28/80 | | 2b HOUR
8:53 AM | |
| 3 SEX
Male | | 4 RACE
Caucasian | | 5 DATE OF BIRTH
MONTH DAY YEAR
1/28/1893 | | 6 AGE (IN YEARS LAST BIRTHDAY)
87 YRS. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Turkey | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD | |
| 10 CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sylvan Manor Nursing Home | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Engineer | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Navy | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Kensington | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Marcus Der Manuelian | | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Zaroupie Goodzoozian | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | | 16b SOCIAL SECURITY NO.
109-07-8310 | | 17 INFORMANT
ADDRESS
Mary Sue Maddox, same as #13 | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RESPIRATORY FAILURE
5693
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) SEVERE ANEMIA
DUE TO, OR AS A CONSEQUENCE OF
(c) RECTAL PROLAPSE | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 3/21 19 66 , to 4/28 19 80 , that (I) was last saw the deceased alive on 4/22 19 80 , and that (my) best opinion death occurred on the date and hour and from the causes stated above, (I) will will not view the body after death. | | | | | | | |
| 22b SIGNATURE
Leo I. Donovan, M.D. | | | | DEGREE
M.D. | | 22c DATE SIGNED
4/28/80 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e ADDRESS
8218 Wisconsin Avenue, Bethesda, MD | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b DATE
5/1/80 | | 23c NAME OF CEMETERY OR CREMATORY
Mt. Auburn Cemetery | | 23d LOCATION
CITY OR TOWN COUNTY STATE
Cambridge, Massachusetts | |
| 24 FUNERAL DIRECTOR
Robert A. Pumphrey | | | | 25a DATE REGD. BY REGISTRAR
1980 | | | |
| 25b REGISTRAR'S SIGNATURE
Crady | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 0 1 0 6 3 0 | | | |
|--|--|---|--|---|--|--|--|
| 1- FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1 DECEASED NAME (TYPE OR PRINT) GASTON | | | | 2a DATE OF DEATH MONTH DAY YEAR 4-22 1980 | | 2b HOUR 1:22 ^P _M | |
| 3 SEX Male | | 4 RACE White | | 5 DATE OF BIRTH MONTH DAY YEAR 9 27 1897 | | 6 AGE (IN YEARS LAST BIRTHDAY) 82 YRS. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Unknown | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | |
| 10 CITY OR TOWN OF DEATH Silver Springs | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Belpre Nursing Home | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U.S. Army | | 12b KIND OF BUSINESS OR INDUSTRY Military | |
| 13a STATE Maryland | | 13b COUNTY Cecil | | 13c CITY OR TOWN Perry Point | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Unknown | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes 16b SOCIAL SECURITY NO. 217-54-9518 | | | |
| 17 INFORMANT ADDRESS Records, VAMC, Perry Point, Md. 21902 | | | | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2049 Lymphatic Leukemia | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years | | | |
| CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF | | | | (c) DUE TO, OR AS A CONSEQUENCE OF | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (1) this hospital attended the deceased from April 19 80 to April 22 19 80 , that (1) (we) last saw the deceased alive on April 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (2) we did (did not) view the body after death. | | | | | | | |
| 22b SIGNATURE Michael R. Dobardge DEGREE MD | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c DATE SIGNED 4/22/80 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) Michael R. Dobardge | | | | 22e ADDRESS 13975 Conn. Ave. Silver Spring, Md. | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b DATE 25 Apr. 1980 | | 23c NAME OF CEMETERY OR CREMATORY Culpepper National | | 23d LOCATION CITY OR TOWN COUNTY STATE Culpepper Culpepper Virginia | |
| 24 FUNERAL DIRECTOR NAME ADDRESS Tarring Funeral Home, P.A., Aberdeen, Md. 21001 | | | | 25a DATE REC'D. BY REGISTRAR APR 28 1980 | | 25b REGISTRAR'S SIGNATURE Timothy McCreedy | |

BP _____

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MAILED 31

1700

MEDICAL CERTIFICATION

BP _____
DHMH - 17
(VR A15 ME (5))
15M 7/76

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3. *Journal of the American Medical Association*, 1990; 263: 1025-1026.

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2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 2681, 2682, 2683, 26

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Page 2. 10/10/04

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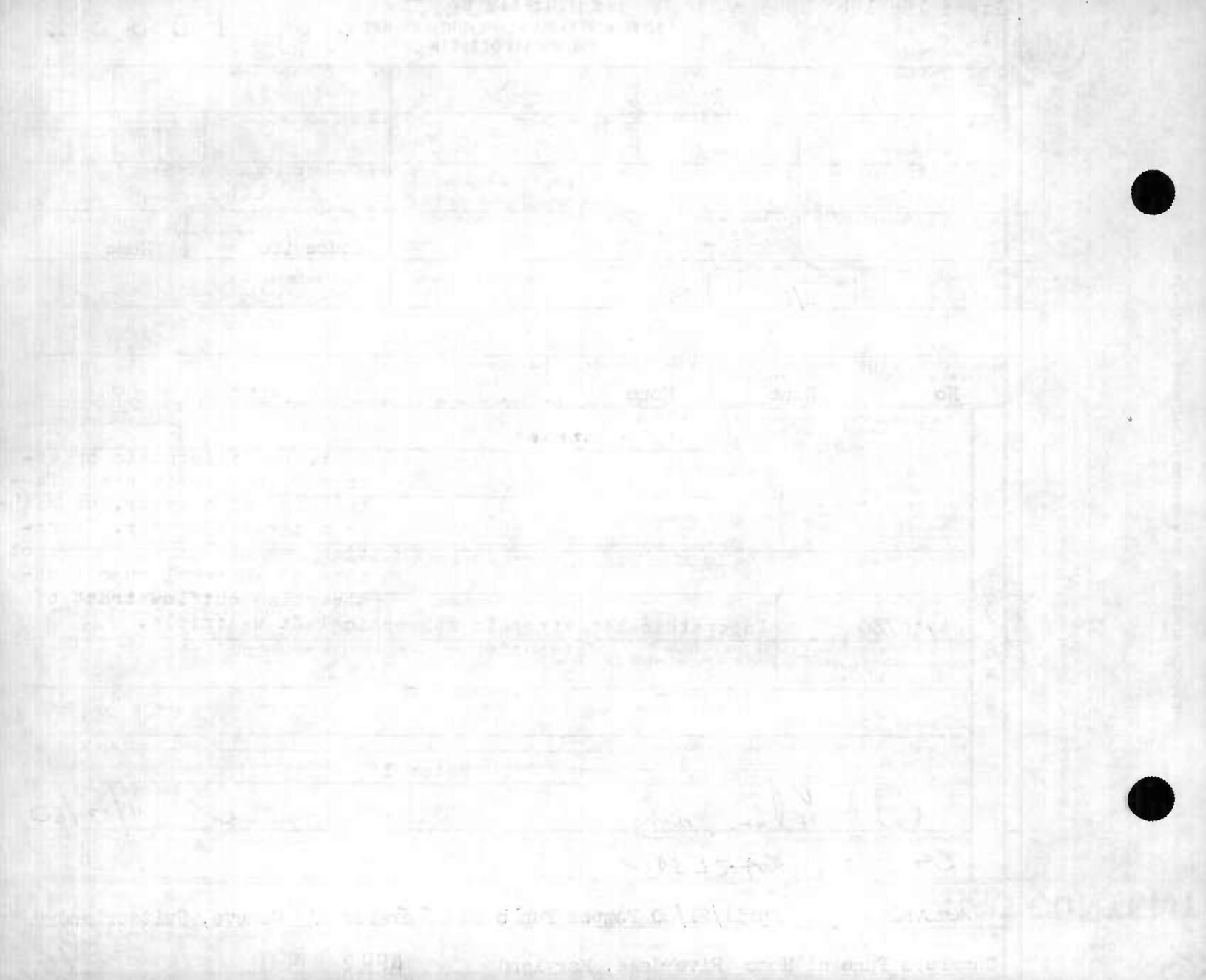
2019. 7. 20

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| Items 19a-19b G543 5/28/80 Dad STATE OF MARYLAND | | | | | | | | | |
|--|--|--|--|---|---|--|--------------------------|---|--------------------|
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| REG. NO. 8 0 1 0 6 3 2 | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | 2b. HOUR |
| Irene Simone Devaud | | | | | | April 16, 1980 | | | 1:25P _M |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR IF UNDER 24 HRS | |
| Female | | White | | October 11 1940 | | 39 YRS. | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Switzerland | | Switzerland | | | | Montgomery County, MD. | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Bethesda | | NIH Clinical Center, Bethesda, Md | | | | Housewife | | Home | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | |
| Switzerland N/A | | | Vesenz | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 12B Chemin Des Gottettes | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | |
| Leon Lappin | | | Mariette Goosens | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO | | 17 INFORMANT ADDRESS | | | | | |
| No | | None | | Mr. Henry Devaud (same as above) | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac arrest | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 4241 | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | Pt. had idiopathic hypertrophic subaortic stenosis - this is not a tumor, but rather a cardiomyopathy. Operative findings consistent with some of abnormal muscle ob- | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Status post myomectomy | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. ADULT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> IF YES, GIVE FINDINGS OF IN CERTIFYING CAUSES OF DEATH? | | | |
| 4/10/80 | | Idiopathic hypertrophic subaortic stenosis | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 5, 1980, to April 16, 1980, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 16, 1980, and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | | | |
| Karl J. Karlson, MD | | | | 4/17/80 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | |
| KARL J. KARLSON | | | | National Institutes of Health Clinical Center, Bethesda, Md. 20205 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Removal | | April 21/80 | | Pompes Funèbres Générales SA | | Geneva, Switzerland | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Chambers Funeral Home Riverdale, Maryland | | | | APR 23 1980 | | Petry/Kelso | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR
1 - STATE
REGISTRAR | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
CLARA ALCINDA DILL | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
April 23, 1980 | | | | 2b. HOUR
6:30 A.M. | | | |
| 3. SEX
Female | | 4. RACE
CAUC. | | 5. DATE OF BIRTH
MONTH DAY YEAR
6 6 1899 | | 6. AGE (IN YEARS LAST BIRTHDAY)
80 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sharon Nursing Home | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | | | |
| 13a. STATE
Md. | | 13b. COUNTY
Howard | | 13c. CITY OR TOWN
Glenwood | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
14402 Dorsey Mill Road | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George LEONARD Dwyer | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Hettie - Brown | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
2B-36-4165 | | 17. INFORMANT
C. Robert B. Dill | | ADDRESS
Olney, Md. | | 20832 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Aspiration of secretions. Suspected
5301
DUE TO, OR AS A CONSEQUENCE OF
(b) Esophagitis
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Immediate
Years | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Chronic obstructive lung disease | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1977, 19, to Apr. 23, 1980, that (I) (we) lost above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Charles E. Taylor MD | | | | DEGREE
M.D.
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
4-23-80 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Charles E. Taylor MD | | | | 22e. ADDRESS
5999 Harper's Farm Rd. Columbia MD 21046 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
April 25, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Carmel | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Sunshine Mont. Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Francis H. Barber | | | | ADDRESS
Laytonsville, Md. 20760 | | | | 25a. DATE REG'D. BY REGISTRAR
APR 28 1980 | | | |
| | | | | | | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

2003

222

22 21

5

basilvian

220

Small pizza/roast

252

1992

2004

2002

1444

11/20/2012

201-12-80

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP _____

DHMH - 16 50M 1/76
(VR A 15 (4))

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | REG. NO. 8 0 1 0 6 3 4 | | | |
|---|--|--|--|---|--|--|--|
| 1 - FOR STATE REGISTRAR | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
James Wm Doss | | | | 2a. DATE OF DEATH MONTH DAY YEAR
4/10/80 | | 2b. HOUR .PM.
6:45 AM | |
| 3. SEX
M | | 4. RACE
W | | 5. DATE OF BIRTH MONTH DAY YEAR
1 6 1918 | | 6. AGE (IN YEARS LAST BIRTHDAY)
62 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
Washington Adventist Hospital | | 12a. USUAL OCCUPATION
truck driver | | 12b. KIND OF BUSINESS OR INDUSTRY
transportation | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE 13b. COUNTY 13c. CITY OR TOWN
Md Howard Jessup | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
Box 297 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Jake Doss | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
unknown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
np | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS
Larry Doss 8354 Luce Ct., Springfield, Va | | | |
| 18. CAUSE OF DEATH - Enter only one cause per line for (a), (b), and (c)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>Metastatic Squamous Cells CA?</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) <u>2° Upper California</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
<u>COPD + CHF</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>[Signature]</u> | | | | DEGREE
M.D. | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
J. GARRIT | | | | 22e. ADDRESS
1109 5 th St. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
April 13, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY
Widener Valley Cem | | 23d. LOCATION
White Glade, Va | |
| 24. FUNERAL DIRECTOR
<u>[Signature]</u> | | | | 25a. DATE REC'D. BY REGISTRAR
APR 17 1980 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

the state

1950-1951

15125

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|------------------------------------|--------------------------------|--------------------------------------|--|-----------------|--|-----------------|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | | 2b. HOUR | | | | |
| FIRST MIDDLE LAST
Ann M. Doyle | | | | | MONTH DAY YEAR
4-29-80 | | | | | 5:55 AM | | | | |
| 3 SEX | | | 4 RACE | | 5 DATE OF BIRTH | | | 6 AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| Female | | | Caucasian | | MONTH DAY YEAR
Feb. 27, 1903 | | | 77 YRS. | | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Pa. | | | USA | | | | | | Montgomery MD. | | | | | |
| 10 CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Silver Spring | | | Holy Cross Hospital | | | Homemaker | | | Home | | | | | |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13b. INSIDE CITY LIMITS? | | | | | 13c. STREET ADDRESS | | | | |
| 13a. STATE COUNTY
Pa. Luzerne | | | | | 13b. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 214 Kidder St. | | | | |
| 14 FATHER'S NAME | | | | | 15 MOTHER'S MAIDEN NAME | | | | | | | | | |
| FIRST MIDDLE LAST
George Stephens | | | | | FIRST MIDDLE LAST
Anna Cooney | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO | | | | | 17 INFORMANT ADDRESS | | | | |
| No | | | | | N/A | | | | | Mrs. James Pendergast 13404 Grenoble DR Rockville, Md. | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) acute myocardial infarction | | | | | | | | | | hours | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | |
| (b) Arteriosclerotic Heart Disease | | | | | | | | | | YRS | | | | |
| (c) | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | |
| Upper Gastrointestinal Bleeding Cholelithiasis | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 21b. TIME OF INJURY | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| | | | | | HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | | 21f. LOCATION | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | | | | STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2:00 2 19 80 to 4:59 80, that (I) (we) last saw the deceased alive on 4/28 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | DEGREE | | 22c. DATE SIGNED | | |
| R.T. Benack | | | | | | | | | | MD | | 4/29/80 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | | | 22e. ADDRESS | | | | |
| R.T. Benack MD | | | | | | | | | | 4115 Colie Drive, Wheaton, Md | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION | | | | |
| Burial | | | | | May 3, 1980 | | Mt. Greenwood Cem | | | Trucksville, Pa. | | | | |
| 24 FUNERAL DIRECTOR NAME ADDRESS | | | | | | | | | | | | | | |
| Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Md. | | | | | | | | | | | | | | |
| DATE REC'D BY REGISTRAR | | | | | | | | | | DATE SIGNED BY REGISTRAR | | | | |
| MAY 6 1980 | | | | | | | | | | | | | | |

May 1950

Washington

Mr. Tolson

214 11th St.

William H. Hays

Mr. Hays

Mr. Hays

Mr. Hays

Mr. Hays

Mr. Hays

Mr. Hays

Mr. Hays

Mr. Hays

May 1950

U.S. Department of Justice

May 1950

Robert A. Hays

Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

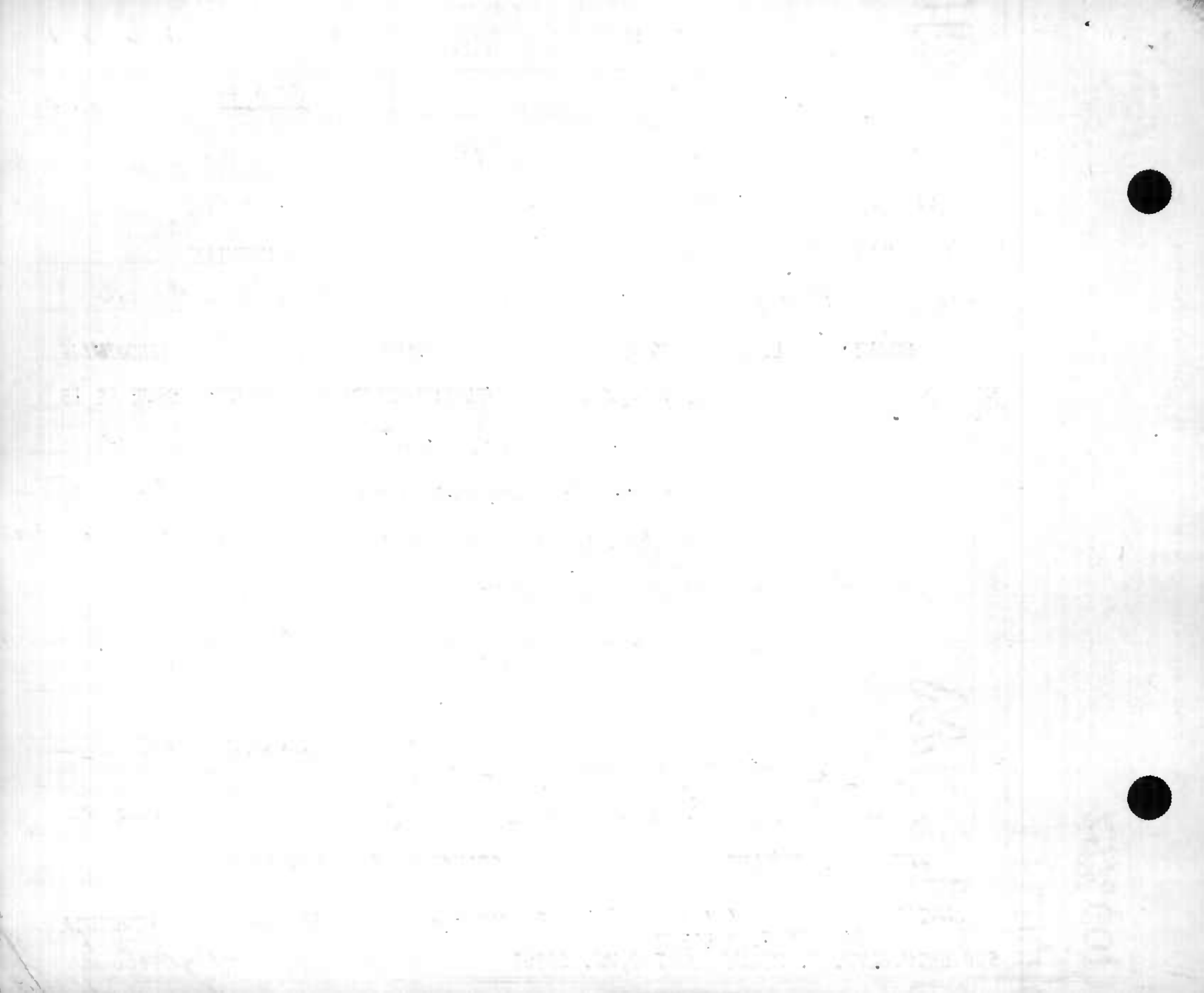
| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|--|---|--|---|---|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | | 2b. HOUR A M | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Rita Marie Driscoll | | | | | April 21, 1980 | | | | | 9:55 A M | |
| 3 SEX
Female | | 4 RACE
White | | 5 DATE OF BIRTH MONTH DAY YEAR
November 9, 1914 | | 6 AGE (IN YEARS LAST BIRTHDAY) YRS.
65 | | 7 UNDER 1 YEAR MONTHS DAYS | | 8 UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WASHINGTON, D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NIH Clinical Center, Bethesda, MD | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
ASSIT. TREASURER | | 12b. KIND OF BUSINESS OR INDUSTRY
AM. S & T | | | | | |
| 13a. STATE
D.C. | | 13b. COUNTY
Washington | | 13c. CITY OR TOWN
Washington | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
2929 Connecticut Ave, NW 20008 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
JOHN T. DRISCOLL | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
ANNIE A. LORING | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | | | 16b. SOCIAL SECURITY NO
579-01-5076 | | 17. INFORMANT ADDRESS
John Driscoll, 4614 Woodfield Rd. Bethesda, MD 20014
Brother | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <u>Brain stem herniation</u>
1830
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }
(b). <u>Widespread ovarian metastatic carcinoma</u>
DUE TO, OR AS A CONSEQUENCE OF
(c).
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>March 20</u> , 19 <u>80</u> , to <u>April 21</u> , 19 <u>80</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>April 21</u> , 19 <u>80</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Joanne K. Tobacman MD | | | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Joanne K. Tobacman | | | | | | 22e. ADDRESS
National Institutes of Health Clinical Center, Bethesda, MD 20205 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | | 23b. DATE
4/24/80 | | 23c. NAME OF CEMETERY OR CREMATORY
MT. OLIVET CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE
WASHINGTON, D. C. | | | |
| 24. FUNERAL DIRECTOR NAME
FRANCIS J. COLLINS | | | | | | 24b. ADDRESS
500 UNIV. BLVD., W., SILVER SPRING, MD, 20901 | | 25a. DATE REC'D. BY REGISTRAR
APR 22 1980 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 0 1 0 6 3 7 | |
|--|---|---|--|--|--|
| 1 - FOR STATE REGISTRAR | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
ELSIE T DYE | | | 2a. DATE OF DEATH MONTH DAY YEAR
APRIL 2 1980 | | 2b. HOUR
0820 P M |
| 3. SEX
F | 4. RACE
W | 5. DATE OF BIRTH MONTH DAY YEAR
11/16/83 | 6. AGE (IN YEARS LAST BIRTHDAY)
96 YRS | 7. UNDER 1 YEAR MONTHS DAYS
7. UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
DC | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
HOLY CROSS HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD 13b. COUNTY MTG 13c. CITY OR TOWN SILVER SPRING | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
11215 OAK LEAF #D1016 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
EDWARD L TODD | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
MARY UNKNOWN | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO X | | 16b. SOCIAL SECURITY NO.
224723023 | 17. INFORMANT ADDRESS
MILDRED KUTTNER DAUGHTER SAME AS 13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>
4140
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Congestive heart failure</u>
6 months
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Arteriosclerotic Heart disease</u>
20+ years | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
inst. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>Azotemia nephrosclerosis</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22. I certify that (1) (this hospital) attended the deceased from 19 75 to April 2 19 80, that (1) (was) lost saw the deceased alive on April 2 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Arthur S. Bresler M.D. | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
4-2-80 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ARTHUR S. BRESLER | | | 22e. ADDRESS
SILVER SPRING, MARYLAND | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
4/7/80 | 23c. NAME OF CEMETERY OR CREMATORY
COLUMBIA GARDENS | | 23d. LOCATION CITY OR TOWN COUNTY STATE
ARLINGTON VIRGINIA |
| 24. FUNERAL DIRECTOR
NAME FRANCIS J. COLLINS ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | 25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
APR 9 1980 [Signature] | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1402 BP

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|---|--|------------------|--|
| 1. FOR
STATE
REGISTRAR | | 2. DECEASED NAME
(TYPE OR PRINT) | | | | 3. DATE OF DEATH | | | | 4. HOUR | |
| | | Edna I. Eadie | | | | Apr 4 80 | | | | 835 P.M. | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. UNDER 1 YEAR | | 8. UNDER 24 HRS | |
| Female | | Caucasian | | 4 19 91 | | 89 YRS. | | MONTHS | | DAYS | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN
COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| New York | | USA | | | | Montgomery County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | |
| Bethesda | | Suburban Hospital | | | | Housewife | | Home | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| Md. | | Montgomery | | Silver Spring | | NO <input type="checkbox"/> | | 2101 Fairland Rd. | | | |
| 14. FATHER'S NAME
(TYPE OR PRINT) | | 15. MOTHER'S MAIDEN NAME
(TYPE OR PRINT) | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 17. SOCIAL SECURITY NO. | | 18. INFORMANT | | | |
| Moses H. Chamberlin | | Mary Payne | | no | | 175 50 4204 | | Louis Eadie 3201 Fullerton St. | | | |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) | | 436- Cardiovascular accident | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | 1 week | | | |
| Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last. | | b) Arteriosclerosis | | | | c) Due to, or as a consequence of | | None | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
Organic Brain Syndrome | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 19c. AUTOPSY? | | 19d. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR | | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| | | P.M. 19 | | | | | | | | | |
| 21a. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21b. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21c. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| | | | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/4/80 to 4/4/80, that (I) (we) lost
saw the deceased alive on 4/4/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22a. SIGNATURE | | 22b. DEGREE | | 22c. ATTENDING PHYSICIAN | | 22d. MEDICAL DIRECTOR | | 22e. STAFF PHYSICIAN | | 22f. DATE SIGNED | |
| Thos G. Ward | | | | X | | | | | | 4/5/80 | |
| 22g. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22h. ADDRESS | | 22i. DATE REC'D. BY REGISTRAR | | 22j. REGISTRAR'S SIGNATURE | | | | | |
| Thos G. Ward | | 6116 Robinson Bethesda | | APR 9 1980 | | Toby McBratney | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | Apr. 9, 1980 | | Riverside Cem. | | Bellfast New York | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS | | | | | | | | | | | |
| PEARSON'S FUNERAL HOME, FALLS CHURCH, VA | | | | | | | | | | | |



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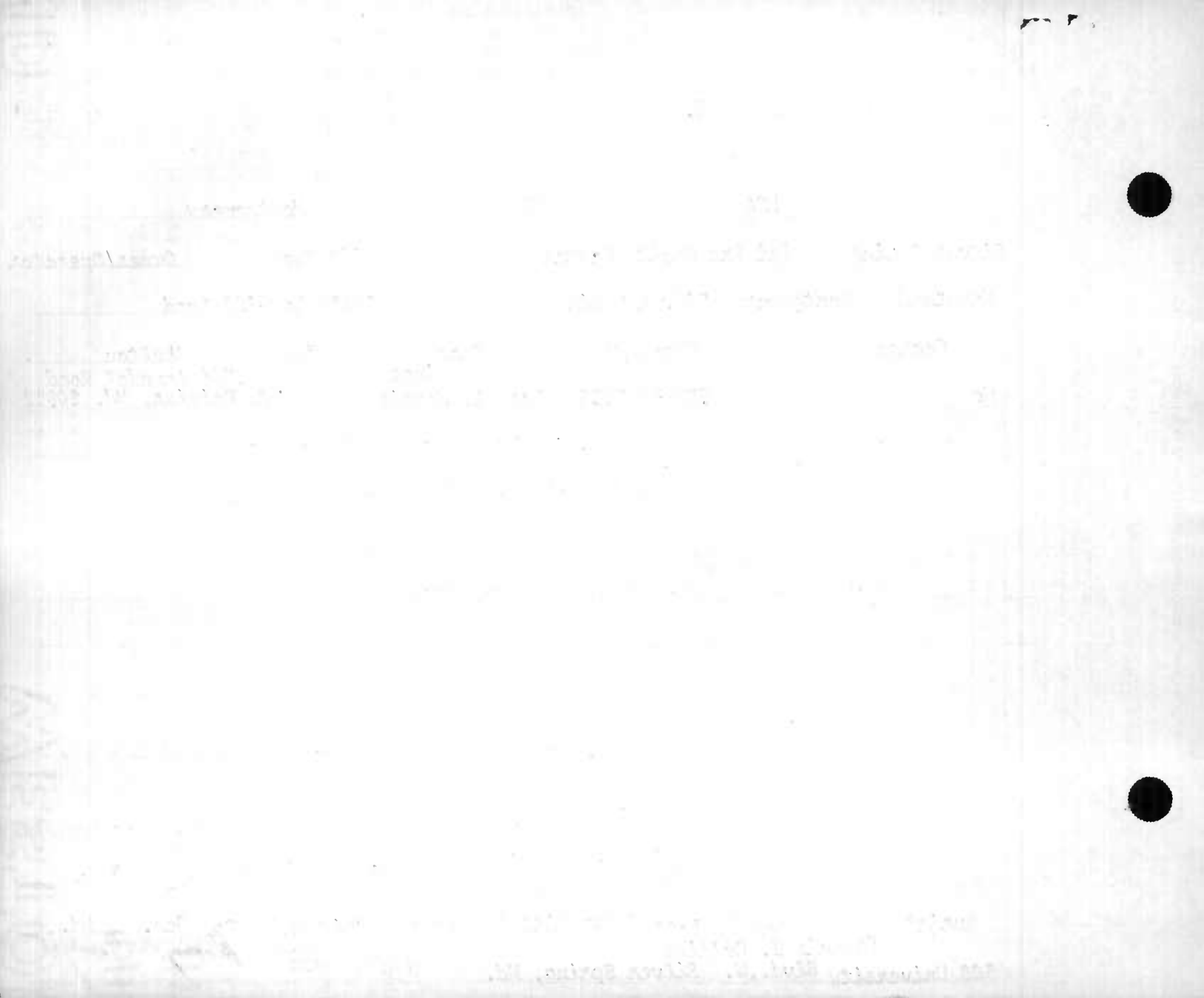
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. 8010639 | | | | | | | | | |
|--|--|--|--|---|--|---|---|------------------------------------|--|-----------------------------|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | 2r. DATE OF DEATH MONTH DAY YEAR | | | | | 2b. HOUR | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
<i>Mary E. Ellenburger</i> | | | | | 4 30 80 | | | | | 4 A M | | | | |
| 3. SEX
<i>7</i> | | 4. RACE
<i>W</i> | | 5. DATE OF BIRTH MONTH DAY YEAR
<i>2 3 1983</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>77</i> YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>England</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery</i> MD. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Silver Spring</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Bel Pre Health Center</i> | | 12r. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Gift Shop</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Owner/Operator</i> | | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE <i>Maryland</i> 13b. CITY OR TOWN <i>Montgomery</i> 13c. CITY OR TOWN <i>Silver Spring</i> | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13r. STREET ADDRESS
<i>13210 Layhill Road</i> | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
<i>George Clements</i> | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
<i>Sarah Jane Skelton</i> | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
<i>No</i> | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)
<i>578-05-7033</i> | | 17. INFORMANT <i>niece</i>
<i>Mary L. Harris</i> | | ADDRESS <i>2706 Arundel Road Mt. Rainier, Md. 20822</i> | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i>
434-
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral Arteriosclerosis</i>
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>hours</i>
<i>years</i> | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<i>Peripheral Vascular Disease</i> | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21r. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21i. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12/8</i> 19 <i>79</i> , to <i>4/30</i> 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>4/29</i> 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>R. T. Benack MD</i> DEGREE <i>MD</i> | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
<i>4/30/80</i> | | | | | | |
| 22a. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>R. T. Benack MD</i> | | | | | 22b. ADDRESS
<i>4115 Colie Drive, Wheaton, MD</i> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>May 2, 1980</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Cedar Hill Cemetery</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE
<i>Suitland Pk. Geo. Md.</i> | | | | | | | | |
| 24. FUNERAL DIRECTOR'S NAME
<i>Francis J. Collins</i> | | | | | 25a. DATE REC'D. BY REGISTRAR
<i>MAY 5 1980</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Anthony McElroy</i> | | | | | | | |
| 500 University Blvd., W. Silver Spring, Md. | | | | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/76
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 1 0 6 4 0

| | | | |
|--|--|---|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
<i>Kim YUNG Yee ENG</i> | | 2a. DATE OF DEATH MONTH DAY YEAR
<i>April 3 1980</i> | |
| 3 SEX
<i>F</i> | | 4 RACE
<i>O</i> | |
| 5 DATE OF BIRTH MONTH DAY YEAR
<i>4 11 06</i> | | 6 AGE (IN YEARS LAST BIRTHDAY) YRS.
<i>73</i> | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Toy Shan, China</i> | | 7b CITIZEN OF WHAT COUNTRY?
<i>Permanent Resident</i> | |
| 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery</i> MD. | |
| 10 CITY OR TOWN OF DEATH
<i>Bethesda</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Suburban</i> | |
| 12a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
<i>Md</i> | | 13b. COUNTY
<i>Montgomery</i> | |
| 13c. CITY OR TOWN
<i>Rockville</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST
<i>Unknown</i> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
<i>Unknown</i> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
<i>No</i> | | 16b. SOCIAL SECURITY NO.
<i>214-74-7197</i> | |
| 17. INFORMANT ADDRESS
<i>Chung Toon Eng-Husband</i> | | <i>Same as # 13</i> | |
| 18 CAUSE OF DEATH Enter only one cause per line (for 18a, 18b, and 18c)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardiorespiratory Failure</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Carcinoma of the Lung</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Carcinoma Gall Bladder</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>4 hrs.</i>
<i>3 hrs.</i>
<i>2 years.</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
<i>Age</i> | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
<i>19</i> | |
| 21a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (the hospital) attended the deceased from <i>4/3/80</i> to <i>present</i> and that in (my) <i>own</i> opinion death occurred on the date and hour and from the causes stated above. (1) <i>is</i> <i>was</i> <i>did not</i> <i>use</i> the body after death. | | | |
| 22b. SIGNATURE
<i>Richard C. Myers</i> | | 22c. DEGREE
<i>MD</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Richard C. Myers, MD</i> | | 22e. ADDRESS
<i>8512 Old Georgetown Rd., Bethesda, Md.</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>April 7, 1980</i> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<i>Fort Lincoln Cemetery</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE
<i>Brentwood, Maryland</i> | |
| 24 FUNERAL DIRECTOR NAME
<i>J. Wm. Lee's Sons Co.</i> | | 25a. DATE REC'D. BY REGISTRAR
<i>APR 8 1980</i> | |
| 25b. REGISTRAR'S SIGNATURE
<i>Robert H. ...</i> | | | |

MEDICAL CERTIFICATION

2
9

97
70
35
151
1

3302 BP

J. M. Lee's home 2037 1/2 N. 2nd St., Wash., D.C.

Don't forget

Remember, Maryland

Barley

1917-18 1000 lbs. Lincoln County

1917-18 1000 lbs. Lincoln County

1917-18 1000 lbs. Lincoln County

o

21-10-1917

China Town Lin-Hua and

home as

Unknown

Unknown

1917-18 1000 lbs. Lincoln County

1917-18 1000 lbs. Lincoln County

1917-18 1000 lbs. Lincoln County

Housewife

1917-18 1000 lbs. Lincoln County

1917-18 1000 lbs. Lincoln County

1917-18 1000 lbs. Lincoln County

1917-18 1000 lbs. Lincoln County

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|
| 1- FOR STATE REGISTRAR | | 7a DATE OF DEATH | | MONTH DAY YEAR | | 2b HOUR | | P | |
| 1 DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a DATE OF DEATH | | MONTH DAY YEAR | | 2b HOUR | |
| Bertha | | EVANS | | Mar 16, '80 | | 7:15 | | AM | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | |
| Female | | Caucasian | | Feb. 22 1888 | | 92 YRS. | | MONTHS DAYS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | MD. | |
| Maryland | | U.S.A. | | | | Montgomery | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| Gaithersburg | | Wilson Health Care Center | | Secretary | | | | | |
| 13a STATE | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? | | 13e STREET ADDRESS | |
| Md. | | Baltimore | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 611 Braeside Rd. | |
| 14 FATHER'S NAME | | 15 MOTHER'S MAIDEN NAME | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT | |
| John | | Robertson | | Lucinda Susan Snyder | | No | | Records 201 Russell Ave., Asbury Methodist Home Gaithersburg, Md. | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4140 | | DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart failure | | DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | 1 week | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 4/15/80 to 4/16/80, that (I) (we) lost saw the deceased alive on 4/15/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | 22b SIGNATURE | | 22c DATE SIGNED | | | | | |
| Thos G. WARD | | 4/17/80 | | | | | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e ADDRESS | | 22f DATE RECD. BY REGISTRAR | | 22g REGISTRAR'S SIGNATURE | | | |
| Thos G. WARD | | 6116 Robinson, Bethesda, Md. | | APR 21 1980 | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | 4/19/80 | | loudon Park Cemetery | | Baltimore Balt. Md. | | | |
| 24 FUNERAL DIRECTOR NAME | | 24b ADDRESS | | 24c CITY OR TOWN | | 24d STATE | | | |
| Gartner-Sandison F. H. | | 316 E. Diamond Ave., Gaithersburg, Md. | | | | | | | |

omitted

4

5. *over* *input* *diff*

[illegible]

3

ok - med examiner CD

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|---|
| 1- FOR STATE REGISTRAR | | REG. NO. 8010042 | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Richard Evans | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
04 28 80 | | | 2b. HOUR
9:55P_M | |
| 3 SEX
Male | | 4 RACE
Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
11 08 16 | | 6 AGE (IN YEARS LAST BIRTHDAY)
63 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10 CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Research Chemist | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Marvin C. Evans | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Martha Toadbine | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
218-26-8837 | | 17 INFORMANT ADDRESS
Patricia F. Evans Same as 13 A | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cardio pulmonary arrest
410-
DUE TO, OR AS A CONSEQUENCE OF (b) inferior MI
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 hrs | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
hypertension | | | | | | | | | |
| 19a. DATE OF OPERATION
— | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
9:55PM 4 28 80 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
— | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
— | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE
— | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/28 , 19 80 , to 4/28 , 19 80 , that (I) (we) lost saw the deceased alive on 4/28 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did) did not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Chas Dyer | | | | DEGREE
MD | | | | 22c. DATE SIGNED
4/28/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Chas Dyer | | | | 22e. ADDRESS
MGH Olney, md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Removal | | 23b. DATE
April 30, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY
Georgetown Univ. Med. School | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Washington, D.C. | | | |
| 24. FUNERAL DIRECTOR NAME
Metropolitan Funeral Service | | | | 24b. ADDRESS
5517 Vine Street Alexandria, Va. | | 25. DATE RECEIVED BY REGISTRAR
MAY 6 1980 | | | |

MEDICAL CERTIFICATION

3202 BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 10843 | |
|--|--|--|--|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST John K. Fangmeyer | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED | | 2b. HOUR | |
| 3. SEX M | | 4. RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR 8 24 18 | | 6. AGE (IN YEARS) LAST BIRTHDAY 61 YRS. | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD | | | | 2c. DATE PRONOUNCED DEAD 4 4 80 | |
| 10. CITY OR TOWN OF DEATH Silver Spg | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY OPTOMETRIST | | | |
| 13a. STATE Maryland | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Silver Spring | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 11405 Newport Mill Rd | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John S. Fangmeyer | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hilda Huggins | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes WW 11 | | 16b. SOCIAL SECURITY NO. 577-24-3969 | | 17. INFORMANT (wife) Theresa G. Fangmeyer-(same as 13e) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis.</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Chronic Myocardial Dis.</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Chronic Obstructive Pulmonary Dis.</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>None</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | | STATE | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) M.D. Dep. MEDICAL EXAMINER | | | | | | DATE SIGNED | | April 7, 1980 | |
| EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, DME | | ADDRESS Silver Spring, Maryland | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 4-8-1980 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington National | | 23d. LOCATION CITY OR TOWN Arlington | | COUNTY | | STATE Virginia | |
| FUNERAL DIRECTOR'S NAME Warner E. Pumphrey, Inc. | | ADDRESS 8434 Ga. Ave., S.S. Md. | | 25a. DATE REC'D. BY REGISTRAR APR 10 1980 | | 25b. REGISTRAR'S SIGNATURE | | | | | |

[Faint, illegible handwriting at the top of the page, possibly a header or address.]

[Faint, illegible handwriting in the middle section of the page.]

[Faint, illegible handwriting at the bottom of the page, possibly a signature or footer.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "other", it shows any injury, or other traumatic event, the medical examiner must be notified at once.

RELEASED BY MEDICAL EXAMINER

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|
| 1- STATE REGISTRAR | | | | | | | | | |
| REG. NO. | | | | | | | | | |
| 1 DECEASED NAME
(TYPE OR PRINT) CELIA | | | | FIRST FEINGOLD | | LAST | | 2a DATE OF DEATH MONTH 4 DAY 9 YEAR 80 | |
| 3 SEX
FEMALE | | 4 RACE
CAUCASIAN | | 5 DATE OF BIRTH MONTH JUNE DAY 20 YEAR 1897 | | 6 AGE (IN YEARS LAST BIRTHDAY) 82 | | 7b HOUR 650 | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY | | MD. | |
| 10 CITY OR TOWN OF DEATH BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b KIND OF BUSINESS OR INDUSTRY | |
| 13a STATE MARYLAND | | 13b COUNTY MONTG'Y | | 13c CITY OR TOWN POTOMAC | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS 10511 RIVER ROAD | |
| 14 FATHER'S NAME FIRST MENDEL MIDDLE --- LAST GREENBERG | | | | 15 MOTHER'S MAIDEN NAME FIRST ROSE MIDDLE --- LAST Lowenthal LOWENSTEIN | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b SOCIAL SECURITY NO 223-05-5166 | | 17 INFORMANT ADDRESS LAWRENCE FRISCH, 10511 RIVER RD, POTOMAC, MD. | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Dehydration | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days | |
| 5609
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) vomitting | | | | | | | | 2 days | |
| (c) Partial intestinal obstruction | | | | | | | | unknown | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
Digitalis intoxication, chronic obstructive lung disease, coronary artery disease, renal failure | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that the deceased was attended by the hospital on November , 19 71 , to April 10 , 19 80 , that he (we) last saw the deceased alive on April 9 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.) | | | | | | | | | |
| 22b SIGNATURE Sidney J. Cohen, M.D. | | | | DEGREE --- | | | | 22c DATE SIGNED 4/10/80 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) Sidney J. Cohen | | | | 22e ADDRESS 121 Congressional Lane, Rockville, Md. | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b DATE 4/13/80 | | 23c NAME OF CEMETERY OR CREMATORY KING DAVID MEM. GAR. | | 23d LOCATION CITY OR TOWN FALLS CHURCH COUNTY VIRGINIA STATE --- | | | |
| 24 FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEM. CHP. ADDRESS ROCKVILLE, MD. | | | | 25a DATE OF REGISTRATION APR 10 1980 | | 25b REGISTRAR'S SIGNATURE --- | | | |

A

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 1 0 6 4 5

1. FOR
STATE
REGISTRAR

REG. NO.

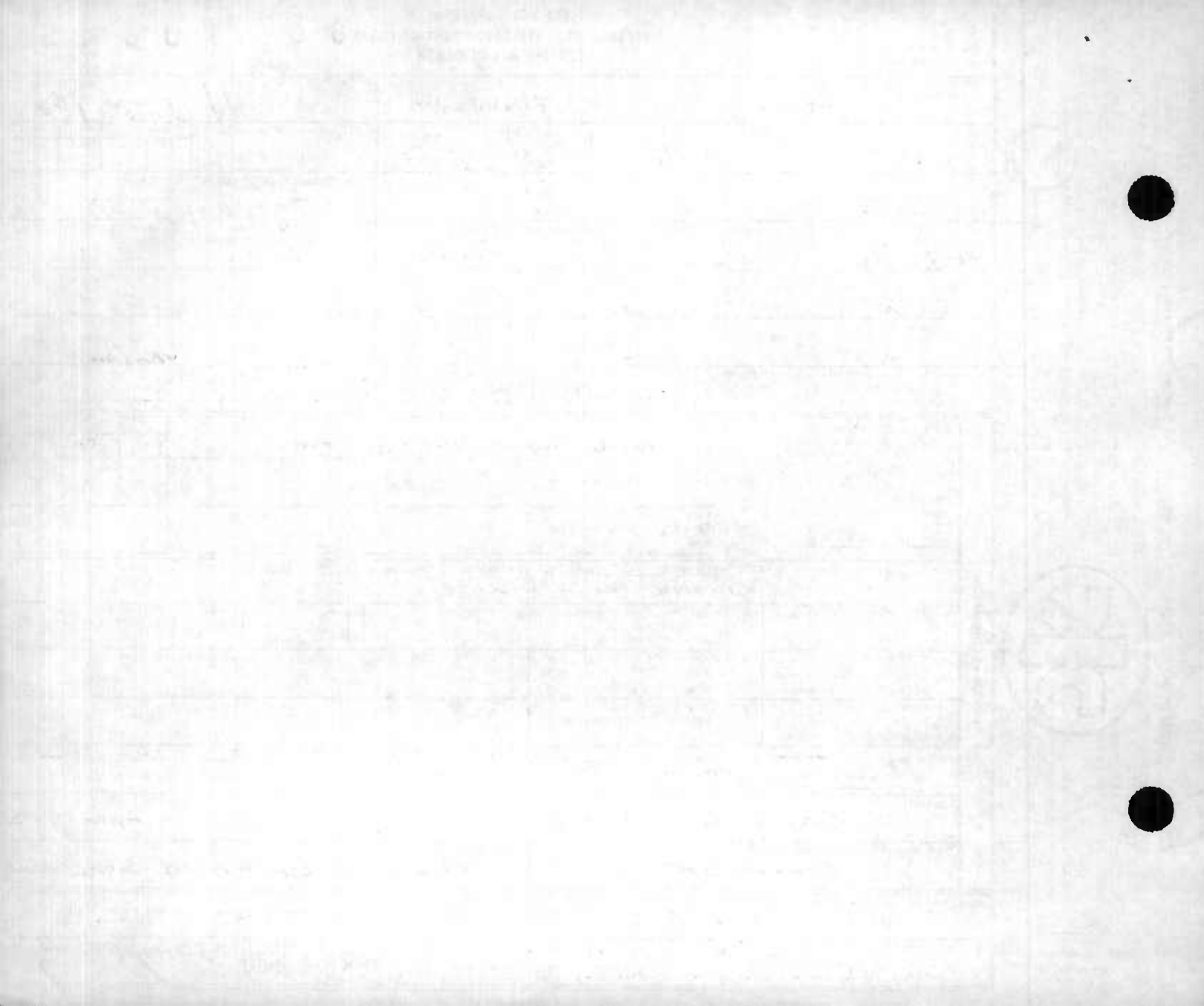
| | | | | | | | | | |
|---|--|---|---|---|------------------------------------|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
ANNA FINEBLUM | | | 2a. DATE OF DEATH
MONTH 4 / DAY 18 / YEAR 1980 | | | 2b. HOUR
1:10 P M | | | |
| 3. SEX
FEMALE F | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH 9 / DAY 28 / YEAR 1894 | | 6. AGE (IN YEARS LAST BIRTHDAY)
85 YRS | | IF UNDER 1 YEAR
MONTHS 0 / DAYS 0 / HOURS 0 / MIN. 0 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Callingswood Nursing Center | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
AT HOME | |
| 13a. STATE
MARYLAND | | | 13b. COUNTY
BALTO. | | 13c. CITY OR TOWN
BALTO. | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST JACOB MIDDLE HARRIS LAST HARRIS | | | 15. MOTHER'S MAIDEN NAME
FIRST MINNIE MIDDLE UNKNOWN LAST UNKNOWN | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | | |
| 17a. SOCIAL SECURITY NO.
215-40-4490A | | | 17. INFORMANT
MR. HARRY FINEBLUM
2702 GEARTNER RD. BALTO., MD 21209 | | | | | | |

| | | | | | |
|---|--|--|--|--|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Acute myocardial infarction
410-
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
1 day | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Chronic Renal Disease | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 11 , 19 78 , to April 18 , 19 80 , that (I) (we) last saw the deceased alive on February 7 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Barry Hecht, M.D. | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
April 18, 1980 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BARRY HECHT | | 22e. ADDRESS
10620 GEORGIA AVENUE SILVER SPRING | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) BURIAL | | 23b. DATE
APR. 20, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY
BETH JACOB ANSHE VESHEAR | |
| 23d. LOCATION
CITY OR TOWN ROSEDALE COUNTY BALTO. STATE MD | | | | | |
| 24. FUNERAL DIRECTOR
NAME SOL LEVINSON & BROS., INC.
ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215 | | 25a. DATE REC'D. BY REGISTRAR
APR 24 1980 | | 25b. REGISTRAR'S SIGNATURE
Barry Hecht | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.



TO HOSPITAL AND ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Pages 3 and 4 should be filed within 72 hours after death. Page 5 should be filed within 72 hours after death. Page 6 should be filed within 72 hours after death. Page 7 should be filed within 72 hours after death. Page 8 should be filed within 72 hours after death. Page 9 should be filed within 72 hours after death. Page 10 should be filed within 72 hours after death. Page 11 should be filed within 72 hours after death. Page 12 should be filed within 72 hours after death. Page 13 should be filed within 72 hours after death. Page 14 should be filed within 72 hours after death. Page 15 should be filed within 72 hours after death. Page 16 should be filed within 72 hours after death. Page 17 should be filed within 72 hours after death. Page 18 should be filed within 72 hours after death. Page 19 should be filed within 72 hours after death. Page 20 should be filed within 72 hours after death. Page 21 should be filed within 72 hours after death. Page 22 should be filed within 72 hours after death. Page 23 should be filed within 72 hours after death. Page 24 should be filed within 72 hours after death. Page 25 should be filed within 72 hours after death. Page 26 should be filed within 72 hours after death. Page 27 should be filed within 72 hours after death. Page 28 should be filed within 72 hours after death. Page 29 should be filed within 72 hours after death. Page 30 should be filed within 72 hours after death. Page 31 should be filed within 72 hours after death. Page 32 should be filed within 72 hours after death. Page 33 should be filed within 72 hours after death. Page 34 should be filed within 72 hours after death. Page 35 should be filed within 72 hours after death. Page 36 should be filed within 72 hours after death. 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Page 55 should be filed within 72 hours after death. Page 56 should be filed within 72 hours after death. Page 57 should be filed within 72 hours after death. Page 58 should be filed within 72 hours after death. Page 59 should be filed within 72 hours after death. Page 60 should be filed within 72 hours after death. Page 61 should be filed within 72 hours after death. Page 62 should be filed within 72 hours after death. Page 63 should be filed within 72 hours after death. Page 64 should be filed within 72 hours after death. Page 65 should be filed within 72 hours after death. Page 66 should be filed within 72 hours after death. Page 67 should be filed within 72 hours after death. Page 68 should be filed within 72 hours after death. Page 69 should be filed within 72 hours after death. Page 70 should be filed within 72 hours after death. Page 71 should be filed within 72 hours after death. Page 72 should be filed within 72 hours after death. 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Page 91 should be filed within 72 hours after death. Page 92 should be filed within 72 hours after death. Page 93 should be filed within 72 hours after death. Page 94 should be filed within 72 hours after death. Page 95 should be filed within 72 hours after death. Page 96 should be filed within 72 hours after death. Page 97 should be filed within 72 hours after death. Page 98 should be filed within 72 hours after death. Page 99 should be filed within 72 hours after death. Page 100 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | | 2c. MIN | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | |
| JOSEPH CLINTON FLOOD | | MALE | | WHITE | | MAY 5, 1895 | | 8:40A. M. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10. CITY OR TOWN OF DEATH | |
| WASHINGTON, D. C. | | U.S.A. | | MONTGOMERY | | OLNEY | | BROOKE GROVE FOUNDATION | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STREET ADDRESS | | 13b. CITY OR TOWN | |
| BROOKE GROVE FOUNDATION | | I.R.S. | | | | 3630 GLENEAGLES DRIVE | | SILVER SPRING | |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) | | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| RICHARD J. FLOOD | | KATHERINE GROMLEY | | YES | | 579-56-7256 | | AGNES M. FLOOD SAME AS 13 WIFE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):) | | 19. IMMEDIATE CAUSE (a) | | 20. DUE TO, OR AS A CONSEQUENCE OF (b) | | 21. DUE TO, OR AS A CONSEQUENCE OF (c) | | 22. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 4465 | | Pulmonary embolus | | Massive repeated stroke due to cerebral thromboses | | Heart cell atrophy (Biopsy proven) | | minutes | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | 23a. DATE OF OPERATION | | 23b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 23c. AUTOPSY? | | 23d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 24a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 24b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 24d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 24e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| | | P.M. 19 | | | | | | 24f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 25a. I certify that (I) (this hospital) attended the deceased from 4/12/80, 1978, to 4/12/80, 1980, that (I) (we) lost | | 25b. SIGNATURE | | 25c. DATE SIGNED | | 25d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 25e. ADDRESS | |
| saw the deceased alive on 7 April 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | Gustavo S. Belaval, MD | | 12 April 80 | | Gustavo S. Belaval | | Leisure world Medical center Silver Spring, MD 20906 | |
| 26a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 26b. DATE | | 26c. NAME OF CEMETERY OR CREMATORY | | 26d. LOCATION CITY OR TOWN COUNTY STATE | | 26e. DATE REC'D. BY REGISTRAR | |
| BURIAL | | 4/15/80 | | GATE OF HEAVEN | | SILVER SPRING MONT MD. | | APR 17 1980 | |
| 27a. FUNERAL DIRECTOR NAME ADDRESS | | 27b. REGISTRAR'S SIGNATURE | | 27c. REGISTRAR'S NAME | | 27d. REGISTRAR'S ADDRESS | | 27e. REGISTRAR'S PHONE NO. | |
| FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | Dorothy McCreedy | | Dorothy McCreedy | | Dorothy McCreedy | | Dorothy McCreedy | |

500 UNIT, BLUE, W. SILVER SPRING, ID, 20901

FRANCIS J. COLLINS

4/15/80

SEE IN NEWSP

STREET SPRING

WONT

APR 12 1980

[Handwritten signature]

YES

BOY 1

579-24-7024

AGNES H. FLOOD

SALE AS IS

WIFE

RICHARD

J.

FLOOD

KATHERINE

GRONLEY

MARYLAND MONTGOMERY

STREET SPRING

2830 GLENDALES DRIVE

OLNEY

BROOK GROVE FUNDATION

T.R.S.

WASHINGTON, D.C. U.S.A.

MONTGOMERY

WIFE

WIFE

INV. 2, 1932

1932

WASHINGTON

FLOOD

APR 12 1980

2100A

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8010647 | |
|--|--|--|---|--|--|---|--|--|--|---------|--|
| 1. FOR STATE REGISTRAR | | | REG. NO. | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST
Vincent | | | MIDDLE
Thomas | | | LAST
Flood | | |
| 2a. DATE OF DEATH | | | MONTH
4 | | | DAY
4 | | | YEAR
80 | | |
| 2b. HOUR
9 ³⁰ P.M. | | | 3. SEX
male | | | 4. RACE
White | | | 5. DATE OF BIRTH | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) | | | MONTH
10 | | | DAY
26 | | | YEAR
21 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
MARYLAND | | | 13b. COUNTY
MONTGOMERY | | | 13c. CITY OR TOWN
SILVER SPRING | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | |
| 17. INFORMANT | | | 18. ADDRESS | | | 19. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION | | |
| 22a. SIGNATURE | | | 22b. DEGREE | | | 22c. DATE SIGNED | | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | |
| 22e. ADDRESS | | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | |
| 23d. LOCATION | | | 23e. DATE REC'D. BY REGISTRAR | | | 23f. REGISTRAR'S SIGNATURE | | | 23g. STATE | | |

11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory failure
4275
DUE TO, OR AS A CONSEQUENCE OF
(b) Cerebral anoxia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
DUE TO, OR AS A CONSEQUENCE OF
(c) Cardiac arrest
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
30 min
11 days
11 days

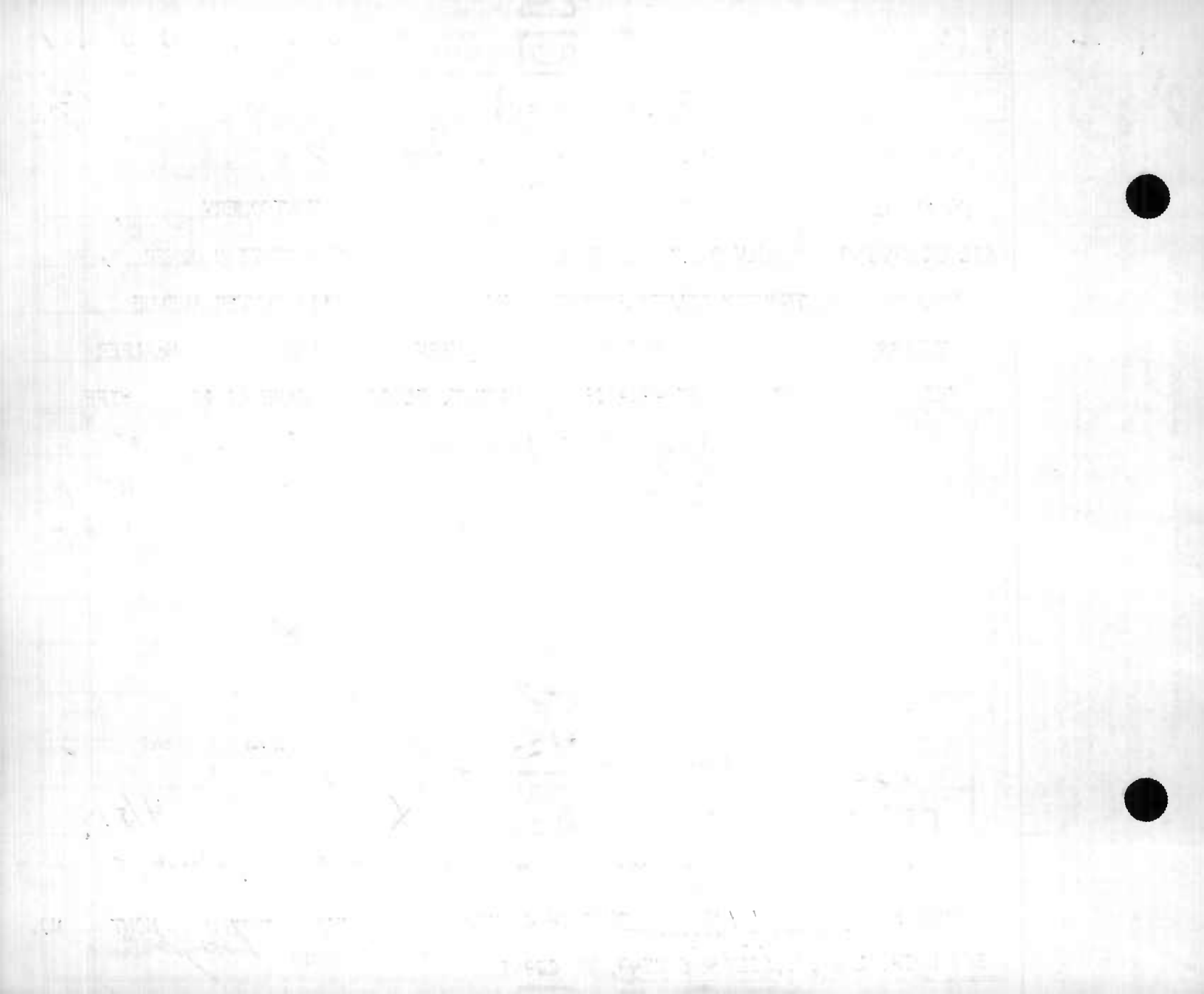
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

21. I certify that (I) (this hospital) attended the deceased from 3/25, 19 80, to 4/4, 19 80, that (I) (we) last saw the deceased alive on 4/4, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.

22a. SIGNATURE Peter B. Sherer MD
22b. DEGREE MD
22c. DATE SIGNED 4/5/80
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PETER B. SHERER MD
22e. ADDRESS 6410 ROCKLEDGE DR #308 Bethesda, Md. 20814

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL
23b. DATE 4/8/80
23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN
23d. LOCATION SILVER SPRING MONT MD
23e. DATE REC'D. BY REGISTRAR APR 9 1980
23f. REGISTRAR'S SIGNATURE [Signature]
23g. STATE MD

24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS
24b. ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901



1 - FOR
STATE
REGISTRAR

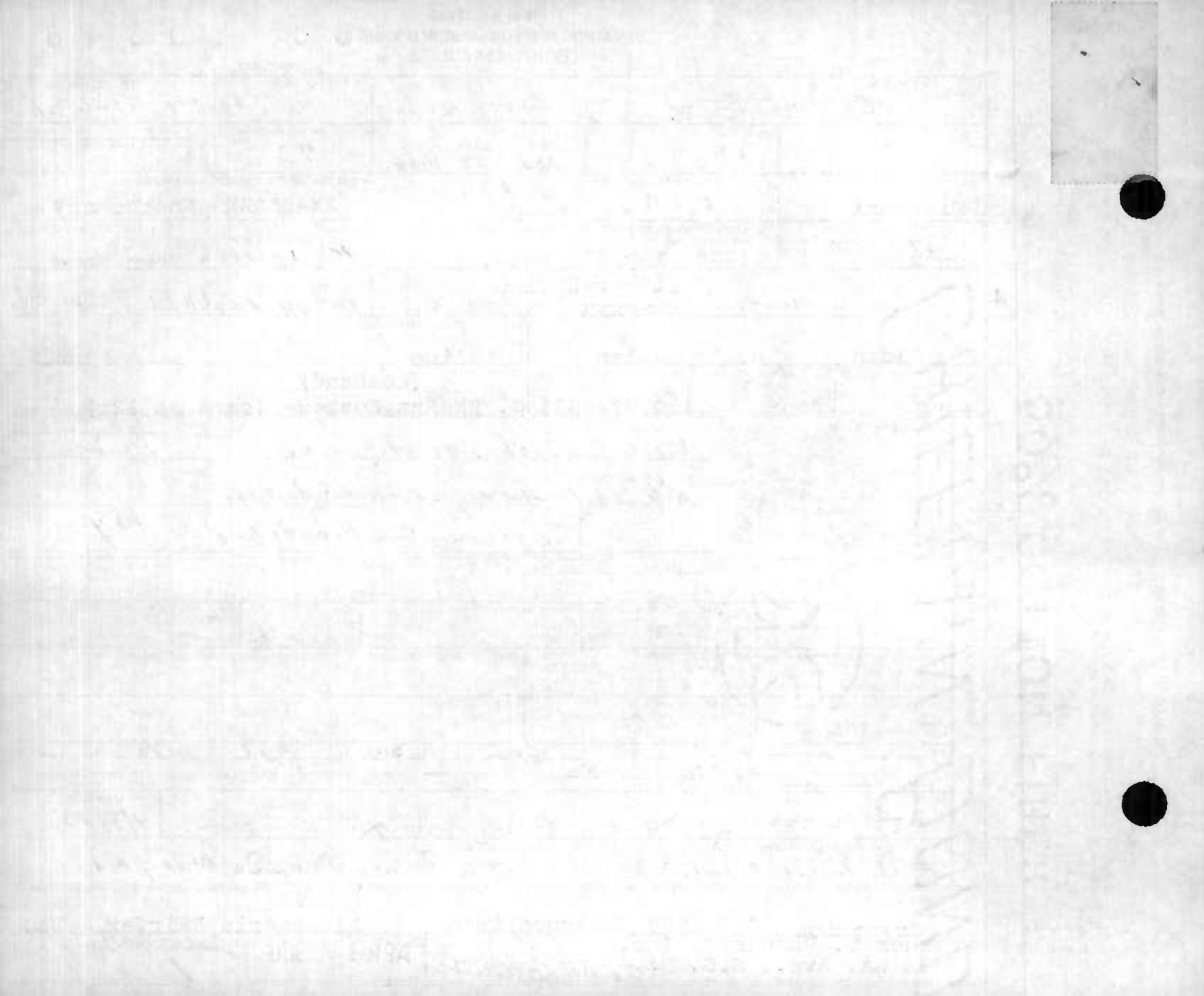
| | | | | | | | | | | | |
|---|--|---|--|---|---|--|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) CATHERINE P. FOSTER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
April 8 1980 | | | 2b. HOUR
6:30 A.M. | | | | | |
| 3. SEX
F | | 4. RACE
W | | 5. DATE OF BIRTH
MONTH DAY YEAR
Nov. 23 1906 | | 6. AGE (IN YEARS LAST BIRTHDAY)
73 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Missouri | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
XXXXXXX Montgomery MD | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
14704 Layhill Road, | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
own home | | | |
| 13a. STATE
Md. | | | 13b. COUNTY
Montg. | | | 13c. STREET ADDRESS
14704 Layhill Rd, Sil. Spn. Md. | | | 13d. CITY OR TOWN
Silver Spring | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Alden W. Allen | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Allen Penn. | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) no | | | | 16b. SOCIAL SECURITY NO.
110-07-9521 | |
| 17. INFORMANT
Rhoads (husband) | | | ADDRESS
J. Rhoads Foster - (same as 13c) | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1: DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute congestive heart failure
DUE TO, OR AS A CONSEQUENCE OF
(b) Arteriosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
(c) Chronic Cong. Heart Failure
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LOST
4292
10 yrs. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Minutes | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan , 19 60 , to Apr , 19 80 , that (I) (we) last saw the deceased alive on 3/24 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (do not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
A.D. Bonifant | | | DEGREE
M.D. | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
4/8/80 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
A.D. BONIFANT | | | 22e. ADDRESS
18111 Prince Philip Dr Olney Md. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | | 23b. DATE
4-9-1980 | | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Alexandria Fairfax Va. | | 23e. DATE REC'D. BY REGISTRAR
APR 11 1980 | | |
| 24. FUNERAL HOME
NAME
Warner E. Pumphrey, Inc. | | | ADDRESS
8434 Ga. Ave., S.S. Md. | | | 25. DATE REC'D. BY REGISTRAR
APR 11 1980 | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



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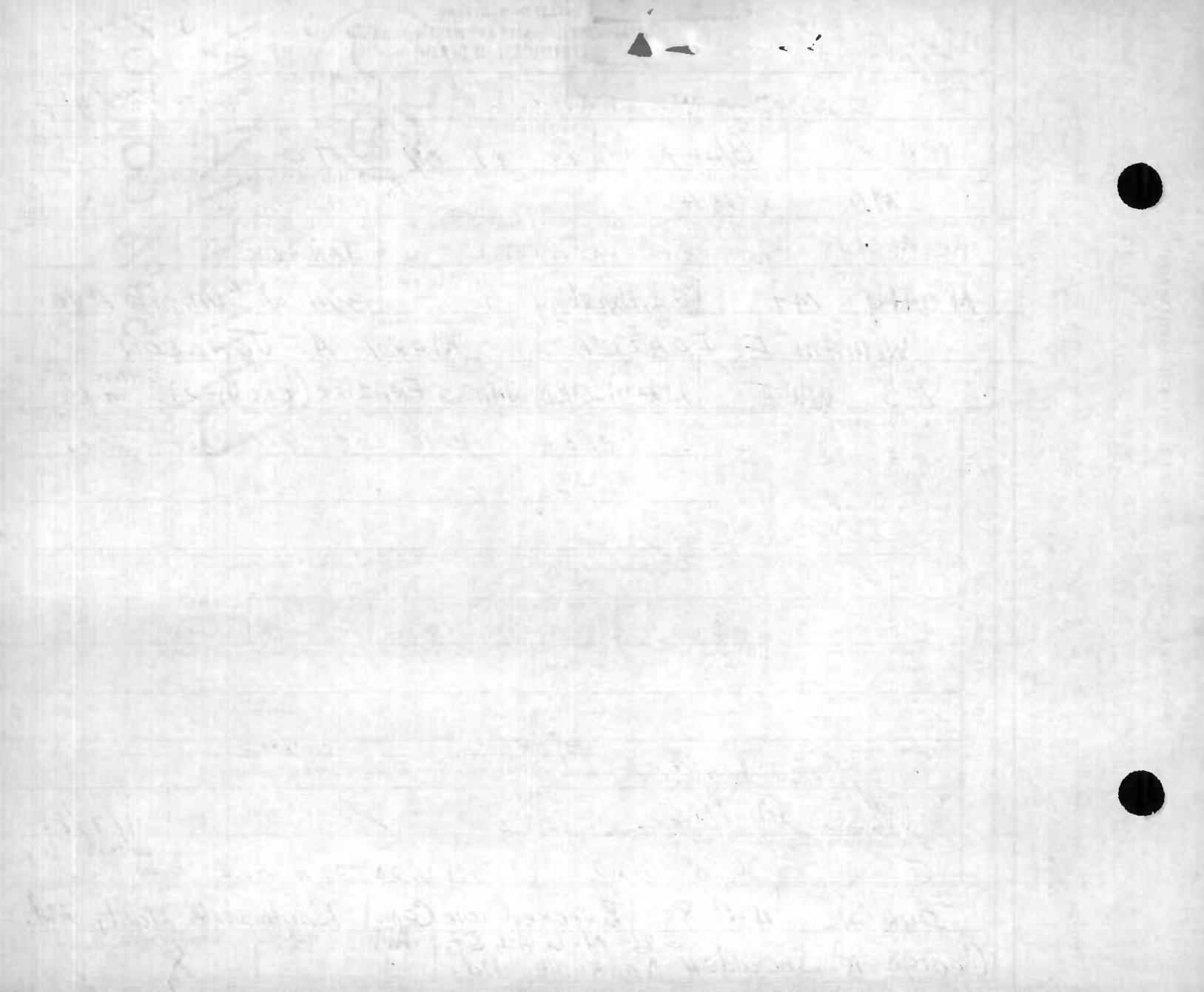
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 70 10649 | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
EDWIN W. FRAZIER | | | | 2a. DATE OF DEATH MONTH DAY YEAR
4-7-80 | | | |
| 3. SEX
MALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 01 09 | | 6. AGE (IN YEARS LAST BIRTHDAY)
70 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SUBURBAN HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
JANITOR | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Montg | | | | 13b. COUNTY
MD | | 13c. CITY OR TOWN
Gaithersburg | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William E. Frazier | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary A. Johnson | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR DATES)
WWII | | 17. INFORMANT
JAMES FRAZIER (Brother) | | ADDRESS
SAME AS #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebro-vascular Accident
1629
DUE TO, OR AS A CONSEQUENCE OF
(b) METASTATIC CA LUNG
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
8 hrs. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION
4/3/80 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
metastatic Rx femur | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/3/80, 19____, to 4/7/80, 19____, that (I) (we) lost saw the deceased alive on 4/7/80, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Thomas F. Ryan MD | | | | DEGREE
MD | | 22c. DATE SIGNED
4/7/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Thomas F. Ryan MD | | | | 22e. ADDRESS
5401 Western Ave. N.W. | | 22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
4-11-80 | | 23c. NAME OF CEMETERY OR CREMATORY
Brooke Grove Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Laytonsville Montg Md. | |
| 24. FUNERAL DIRECTOR
NAME
George R. Snowden | | | | 24b. ADDRESS
246 N. WASH. ST.
Rockville Md. | | 25a. DATE REC'D. BY REGISTRAR
APR 11 1980 | |

MEDICAL CERTIFICATION

0701

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 0 1 0 6 5 0 | | |
|--|--|---|--|---|--|--|--------------------------------------|-----------------------------------|---|---|-----------------|--|
| 1. FOR
STATE
REGISTRAR | | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE OF DEATH | | | MONTH DAY YEAR | | 2b. HOUR | |
| Robert James FREY | | | | | | 4 22 80 | | | 7:15 | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| Male | | CAUC. | | MONTH DAY YEAR
11 14 30 | | | 49 | | MONTHS DAYS | | HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| PA. | | USA | | | | | MONTGOMERY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| G'burg | | SHADY GROVE AID HOSP | | | Retired | | | Auto Management | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13a. INSIDE CITY LIMITS? | | 13b. STREET ADDRESS | | | | | | |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 11620 BEDFORD CT. | | | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| FIRST MIDDLE LAST | | | | FIRST MIDDLE LAST | | | | | | | | |
| unknown | | | | HELEN | | BLISSECK | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT ADDRESS | | | | | | |
| NO | | | | -- | | 578 42 2271 LAURA T. HORN 11620 Bedford Ct. (daughter) | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 3949 Cordic arrest | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | 10 min | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) Congestive heart failure | | | | | | | | | | 2 yrs. | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | years. | | |
| (c) mild valve disease - possible bacterial endocarditis | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):
peripheral emboli to femoral arteries | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| | | | P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET | | | CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/21 19 80 to 4/22 19 80, that (I) (we) lost saw the deceased alive on 4/22 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | | 22c. DATE SIGNED | | | |
| Samuel D. Goldberg MD | | | | | | | | | 4-22-80 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e. ADDRESS | | | | | | |
| Samuel D. Goldberg MD | | | | | | 11125 Rockville Pike, Rockville, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| Burial | | | 4/25/80 | | | Gate of Heaven | | | Silver Spring, Maryland | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. DATE OF DEATH | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Tyson Wheeler Funeral Home, Inc.
1331 Rockville Pike Rockville, Maryland | | | | | | APR 25 1980 | | | | | | |

12/2/71

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. UNDER 1 YEAR | |
| MALE | | CAUCASIAN | | MONTH DAY YEAR | | 89 YRS | | MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | MD. | |
| MARYLAND | | USA | | SEPT. 15, 1890 | | Montgomery | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Bethesda Md | | Furman Hospital | | RESTAURANT | | OWNER | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13d. STREET ADDRESS | | | |
| D.C. | | WASHINGTON | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 4600 CONNECTICUT AVE. | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| AVRAM | | FANNIE | | NO | | 577-50-7071 | | NORMAN FURMAN, 1400 CRESTRIDGE DR. SILV. SP. MD. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 19. IMMEDIATE CAUSE (a) | | 20. DUE TO, OR AS A CONSEQUENCE OF | | 21. DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 410- | | CORONARY OCCLUSION | | CORONARY ARTERIO SCLEROSIS | | | | 24 hours | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| Metastatic Cancer | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| | | HOUR A.M. MONTH DAY YEAR | | | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (the hospital) attended the deceased from | | 22b. SIGNATURE | | 22c. DEGREE | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | |
| 4/17/80, to 4/18/80, that (we) lost | | Norman A. Furman | | ATTENDING PHYSICIAN | | NORMAN A. FURMAN | | 8200 WILCOX AVE. BALTIMORE | |
| above, (we) (do not) view the body after death. | | 4/18/80 | | MEDICAL DIRECTOR <input checked="" type="checkbox"/> PHYSICIAN <input type="checkbox"/> STAFF <input type="checkbox"/> | | 4/19/80 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | COUNTY STATE | |
| BURIAL | | 4/21/80 | | KING DAVID MEM. GARDEN | | FALLS CHURCH, VIRGINIA | | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE OF DEATH | | 25b. BY REGISTRAR | | 25c. REGISTRAR'S SIGNATURE | | | |
| DANZANSKY-GOLDBERG MEM. CH., ROCKVILLE, MD. | | APR 20 1980 | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, papers should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 1 0 6 5 2
CERTIFICATE OF DEATH

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Gwendolyn Gallimore | | | | 2a. DATE OF DEATH MONTH DAY YEAR
April 3, 1980 | | | | 2b. HOUR
11:20 | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
July 28 1927 | | 6. AGE (IN YEARS LAST BIRTHDAY)
52 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
England | | 7b. CITIZEN OF WHAT COUNTRY?
Not available | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Germantown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
15800 Darnestown Road | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE 13b. COUNTY
Maryland Montgomery | | | | 13c. CITY OR TOWN
Germantown | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
15800 Darnestown Road | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Adams | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ada Not available | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
212 84 2675 | | 17. INFORMANT ADDRESS
Victor Gallimore same as item 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Ischemic heart disease | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 months | |
| 2500 } DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Diabetes Mellitus | | | | | | | | 20 years | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Chronic renal insufficiency; Hypertension; Aneurysm | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 31, 1979 , to March 20, 1980 , that (I) (we) lost saw the deceased alive on March 20, 1980 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Allen A. Nimetz M.D. DEGREE MD | | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
4/4/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Allen A. Nimetz M.D. | | | | | | 22e. ADDRESS
5401 Western Avenue N.W. D.C. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Anatomical Gift | | | 23b. DATE
4/3/80 | | 23c. NAME OF CEMETERY OR CREMATORY
Howard University | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington D.C. | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND | | | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
APR 14 1980 <i>Robert A. Pumphrey</i> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

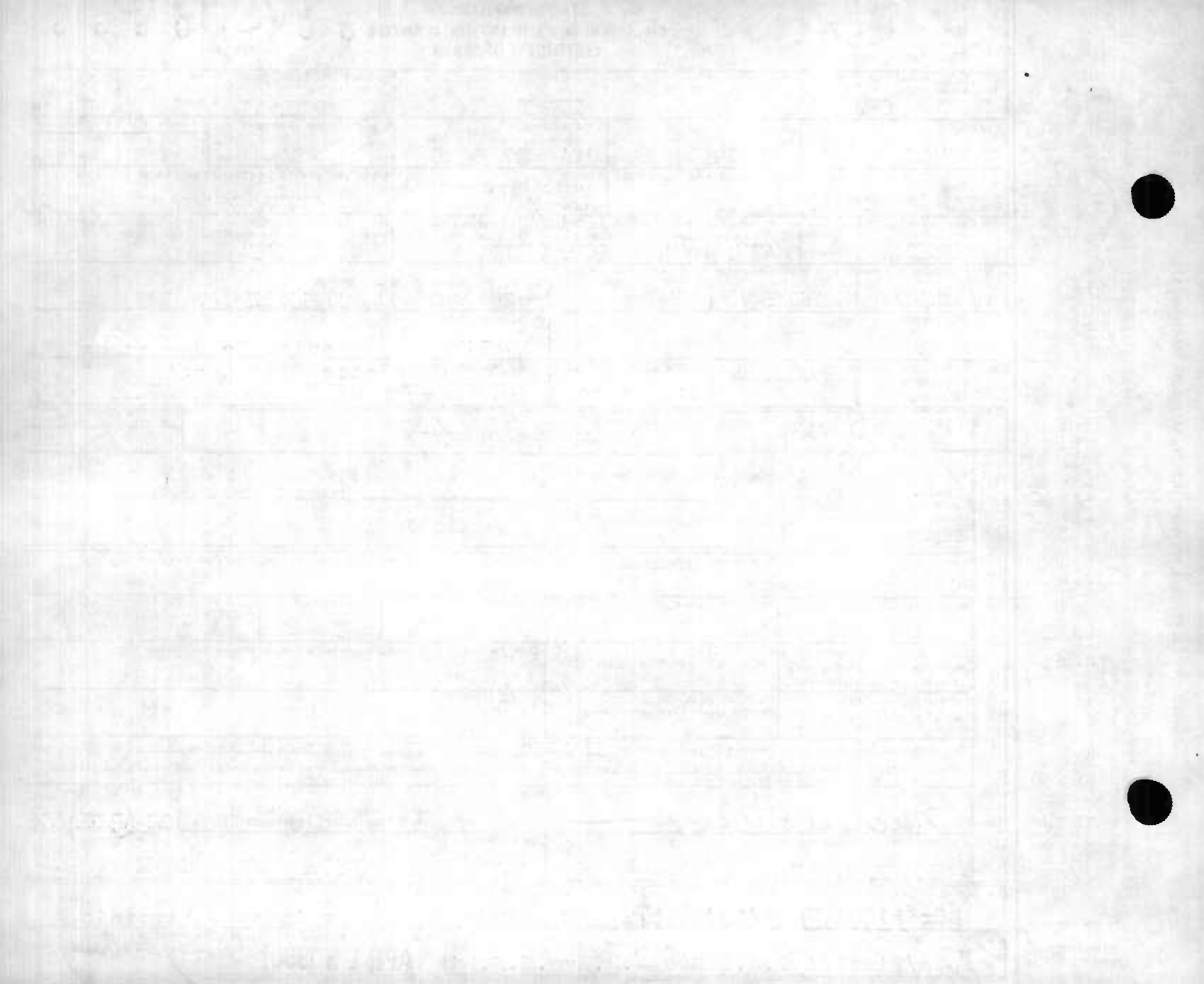
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 1 0 8 5 3

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|---|--|---|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
CHARLOTTE L. GERBER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
APRIL 12, 1980 | | | 2b. HOUR
0004 AM | |
| 3. SEX
FEMALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
MAY 07, 1895 | | 6. AGE (IN YEARS LAST BIRTHDAY)
84 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
DIST. OF COLUMBIA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NAT'L NAVAL MEDICAL CENTER | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
WHEATON | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
HERMANN STOBBE | | | | 15. MOTHER'S NAME
FIRST MIDDLE LAST
Amalie Louise VonSuchotzka | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
338 24 0266 | | 17. INFORMANT Charlotte ADDRESS Curtis
Daughter 240 MAWBRAY RD. COLESVILLE, MD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BACTERIAL ENDOCARDITIS
4210
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 09 APRIL 1980, to 12 APRIL 1980, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 11 APRIL 1980, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (do not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Michael J. Duran | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12 APRIL 1980 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MICHAEL J. DURAN M.D. | | | | 22e. ADDRESS
NAT'L NAVAL MEDICAL CENTER BETHESDA, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
4/15/80 | | 23c. NAME OF CEMETERY OR CREMATORY
ARLINGTON NAT'L | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arlington, Virginia | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Hines/Rinaldi F.H.11800 N.H.Ave.S.S.Md. | | | | 25a. DATE REC'D. BY REGISTRAR
APR 15 1980 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These please remove carbon-copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 8 0 1 0 6 5 4 | | | |
|---|--|--|--|---|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT)
Blanche L. German | | | | 2a. DATE OF DEATH MONTH DAY YEAR
4/14/80 | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
Oct. 6, 1883 | | 6. AGE (IN YEARS LAST BIRTHDAY)
96 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Michigan | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hosp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | |
| 13a. STATE
Maryland | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
George Power | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Lula White | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
369-01-2132D | | 17. INFORMANT ADDRESS
Mrs. T. R. Martin Same as 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pneumonia (Septis?)</u>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Ascid</u> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (this hospital) attended the deceased from <u>04-14</u> 19 <u>80</u> to <u>04-14</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>04-14</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>H. Weber</u> | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
04-14-80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
H. WEBER | | | | 22e. ADDRESS
WAH. Takoma Park, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Apr. 19 | | 23c. NAME OF CEMETERY OR CREMATORY
Franklin Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Franklin Oakland Michigan | |
| 24. FUNERAL DIRECTOR NAME
Capitol Funeral Service | | | | ADDRESS
Fairfax, Va. | | 25a. DATE REC'D. BY REGISTRAR
APR 22 1980 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<u>Robert M. McCreedy</u> | | | |

Capital Funeral Service
 1500
 Apr. 19
 Franklin Cemetery
 Franklin, Michigan

No. 369-01-51581 Mrs. T. R. Martin Same as 13

George Power
 Maryland Montgomery Silver Spring
 x 1000 Sherwood Rd.
 White

Michigan U.S.A.
 x
 Michigan Ave.
 Housewife

Female Canada
 Cor. E. 103
 444-133
 100

CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | |
|---|--|---|--|---|-----------------------------------|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Ralph E. Gibson | | | 2a. DATE OF DEATH 4-20-80 | | 7b. HOUR 11:07 PM | | | |
| 3. SEX Male | | 4. RACE Caucasian | | 5. DATE OF BIRTH Oct. 7, 1920 | | 6. AGE (IN YEARS LAST BIRTHDAY) 59 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery | | |
| 10. CITY OR TOWN OF DEATH Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hosp. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) Writer-Editor | | 12b. KIND OF BUSINESS OR INDUSTRY NASA | | |
| 13a. STATE Md. | | | 13b. COUNTY Montg. | | 13c. CITY OR TOWN Bethesda | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST Jasper MIDDLE Gibson LAST Alexander | | | 15. MOTHER'S MAIDEN NAME
FIRST Alexander MIDDLE Wells LAST Wells | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. WW 11 | | 17. INFORMANT Claire Gibson | | ADDRESS Same as 13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) VENTRICULAR FIBRILLATION
4/14/80
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) CORONARY ART. DISEASE - VENTRICULAR ANEURYSM - 1 YEAR
(c) CONGESTIVE HEART FAILURE
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 hour
1 YEAR | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) ANEURYSM R. COMMON ILIAC ARTERY + OBSTRUCTION | | | | | | | | |
| 19a. DATE OF OPERATION 4/17/80 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED OBSTRUCTION R. COM. ILIAC ART | | | 20a. AUTOPSY? NO | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) James A. Roman attended the deceased from APRIL 16, 1980 to APRIL 20, 1980 , that (I) lost saw the deceased alive on APRIL 20, 1980 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE James A. Roman | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 4/20/80 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES A. ROMAN | | | | 22e. ADDRESS 7600 CARROLL AVE. TAKOMA PK, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Apr. 24, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY Hillside Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE Laurinburg, N. C. | | |
| 24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Md. | | | | 25a. DATE REC'D. BY REGISTRAR APR 24 1980 | | 25b. REGISTRAR'S SIGNATURE L. H. C. C. | | |

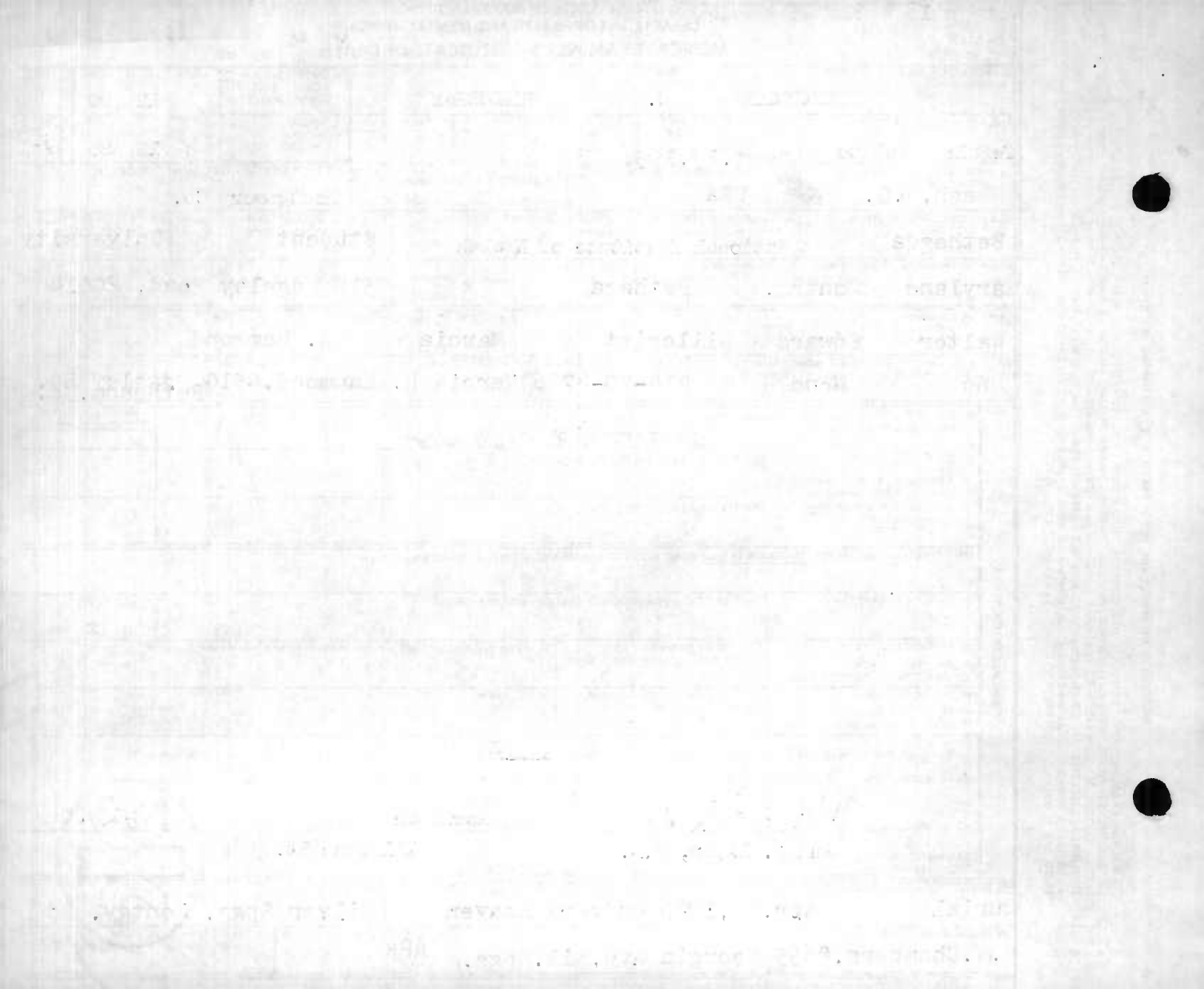
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|-------------------------------------|--|---|--|---|--|---|--|---|--|
| 1- STATE REGISTRAR | | | | | | | | | | 7. DATE KNOWN OF DEATH | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
BERNADETTE C. GILLCRIST | | | | | | | | | | 2. DATE KNOWN OF DEATH ESTIMATED
4 12 1980 | |
| 3. SEX
female | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
Sept 13 1946 | | 6. AGE (IN YEARS)
LAST BIRTHDAY
23 YRS. | | IF UNDER 1 YR.
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Wash, D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery Co. | | 21. DATE PRONOUNCED DEAD
4 12 1980 | | 22. HOUR
8:50 A.M. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
National Institute of Health | | | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)
Student | | 12b. KIND OF BUSINESS OR INDUSTRY
University | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montg. | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
9510 Edgeley Road, 20014 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Walter Edward Gillcrist | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Marcia H. Hammond | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No None | | | | 16b. SOCIAL SECURITY NO.
214-70-4726 | | 17. INFORMANT ADDRESS
Marcia H. Hammond, 9510 Edgeley Rd, Bethesda, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
7999 IMMEDIATE CAUSE (a) Undetermined
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE
Ann M. Dixon, M.D. | | | | TITLE (SPECIFY)
Assistant | | | | DATE SIGNED
4/13/80 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS
111 Penn St. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
Apr. 16, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Silver Spgs, Montg, Md | | | |
| 24. FUNERAL DIRECTOR
NAME
W.W. Chambers, 8655 Georgia Ave, Sil. Spgs. | | | | 25a. DATE REC'D. BY REGISTRAR
APR 17 1980 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | | |

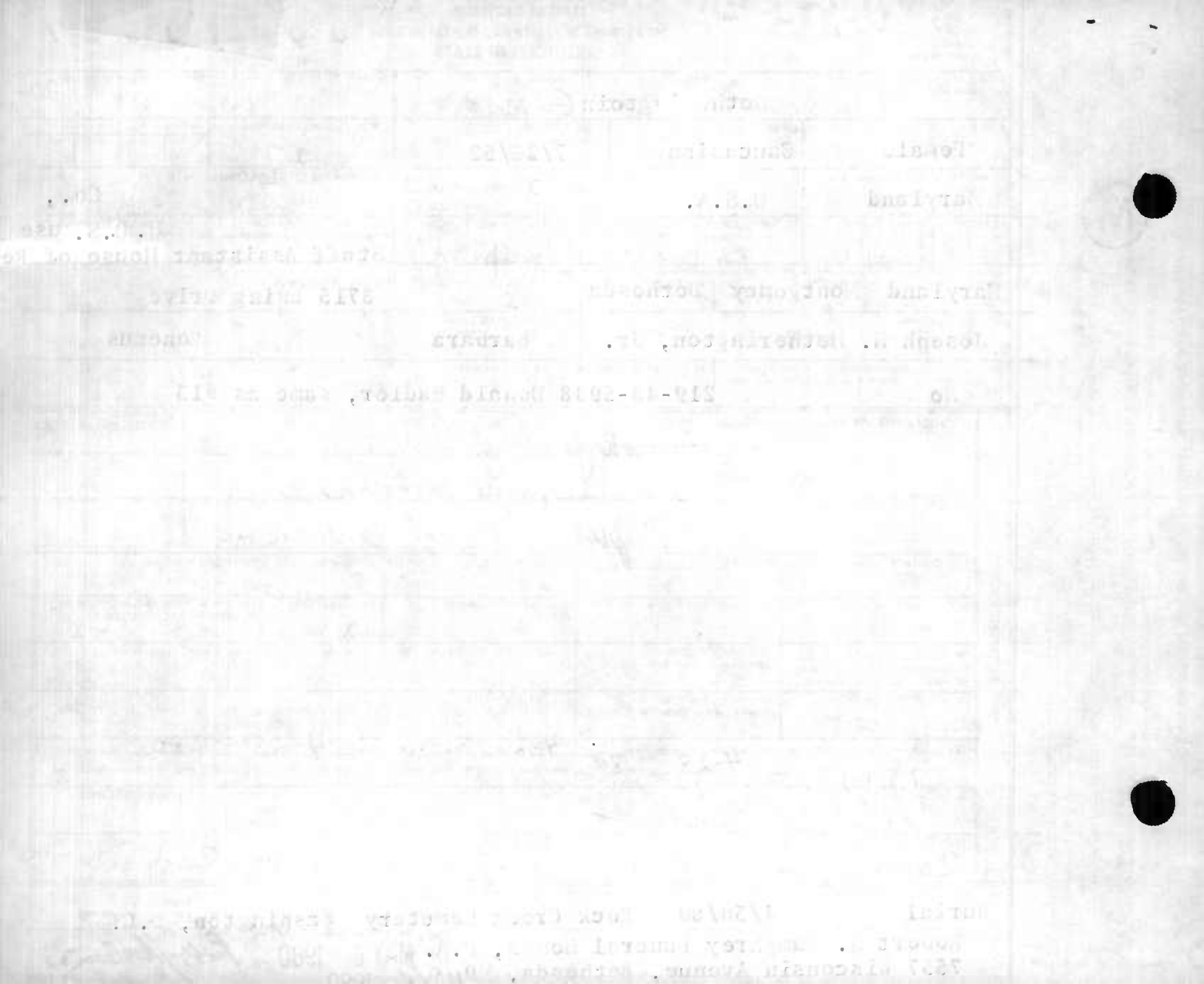


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 8010657 | | | | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a DATE OF DEATH MONTH DAY YEAR | | 2b HOUR PM M | |
| Claudia Hetherington | | Given | | S | | | | 4-28-80 | | 10 PM | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH MONTH DAY YEAR | | 6 AGE (IN YEARS LAST BIRTHDAY) | | 7 IF UNDER 1 YEAR MONTHS DAYS | | 8 IF UNDER 24 HRS HOURS MIN | |
| Female | | Caucasian | | 7/25/52 | | 27 YRS. | | | | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Maryland | | U.S.A. | | | | Montgomery Co. MD. | | | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY | |
| Bethesda | | Suburban Hospital | | | | | | Staff Assistant of Rep. | | U.S. House | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS | | | |
| Maryland | | Montgomery | | Bethesda | | | | 8715 Ewing Drive | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | |
| Joseph H. Hetherington, Jr. | | | | Barbara Ronemus | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17 INFORMANT | | ADDRESS | | | | | |
| No | | 219-48-5988 | | Donald Radler, same as #13 | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Respiratory Arrest</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 430-
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Subarachnoid Hemorrhage</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Ruptured Cerebral Aneurysm</u> | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>4-20</u> 19 <u>80</u> to <u>4-28</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>4-28</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b SIGNATURE | | | | DEGREE | | | | 22c DATE SIGNED | | | |
| <u>Carol L Bender</u> | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e ADDRESS | | | | | | | |
| Carol L. Bender | | | | 11125 Rockville PK. Rockville md. | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | 4/30/80 | | Rock Creek Cemetery | | Washington, D.C. | | | | | |
| 24 FUNERAL DIRECTOR | | | | 25 DATE REC'D. BY REGISTRAR | | | | 25b REGISTRAR'S SIGNATURE | | | |
| Robert A. Pumphrey Funeral Homes, P.A. | | | | MAY 6 1980 | | | | <u>Robert A. Pumphrey</u> | | | |
| 7557 Wisconsin Avenue, Bethesda, MD | | | | MAY 6 1980 | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 1 0 6 5 8

REG. NO.

| | | | | | | | | | | | |
|---|--|---|--|--|--|--|--|--|--|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT) ANNA M. GOAD | | | 2a. DATE OF DEATH MONTH DAY YEAR
4/28/80 | | | 2b. HOUR
5 PM | | | | | |
| 3 SEX
F. | | 4 RACE
CAUC. | | 5 DATE OF BIRTH
MONTH DAY YEAR
6 3 1898 | | 6 AGE (IN YEARS LAST BIRTHDAY)
81 YRS. | | 7 UNDER 1 YEAR
MONTHS DAYS
0 0 | | 7 UNDER 24 HRS
HOURS MIN.
0 0 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10 CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Randolph Hills Nursing Home | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
own home | | | |
| 13a. STATE
Maryland | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Sil. Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
12430 Dewey Road, | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Henry Kahl | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Barbara Nuttenburger | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) no | | | |
| 16b. SOCIAL SECURITY NO
5 79-26-7208 | | | | 17 INFORMANT (son)
Joseph J. Goad-District Hgts. Md. | | | | 18 ADDRESS
6219 Dist. Hgts. Pkwy | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY ARREST | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
436- MINS | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
(b) CEREBRAL VASCULAR ACCIDENT | | | | | | | | | | DAYS | |
| (c) GENERALIZED ARTERIOSCLEROSIS | | | | | | | | | | YEARS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
HYPERTENSIVE CARDIOVASCULAR DISEASE; AZOTEMIA. | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 4/12 , 19 80 , to 4/28 , 19 80 , that (I) (we) lost saw the deceased alive on 4/15 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Harold W. Draper M.D. | | | | | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
4/28/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HAROLD W. DRAPER M.D. | | | | | | 22e. ADDRESS
9801 GEORGIA AVE, Silver Spring Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
May 2, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY
George Washington | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Adelphi Pr. Georges Md. | | | |
| 24 FUNERAL DIRECTOR
Walter E. Pumphrey, Inc. | | | | | | 25. DATE REC'D. BY REGISTRAR
MAY 5 1980 | | 25b. REGISTRAR'S SIGNATURE
Clark E. Wilson | | | |
| 8434 Ga. Ave., S.S. Md. | | | | | | | | | | | |

100

FOR
1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8010659

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST George Goldstein

2a. DATE OF DEATH MONTH DAY YEAR 4-18-80 2b. HOUR 10:35 AM

3. SEX m 4. RACE w 5. DATE OF BIRTH MONTH DAY YEAR 1 25 07 6. AGE (IN YEARS LAST BIRTHDAY) 73 7. UNDER 1 YEAR MONTHS 8. UNDER 24 HRS. HOURS MIN. 73 YRS.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA 7b. CITIZEN OF WHAT COUNTRY? USA 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 9. BALTIMORE CITY OR COUNTY OF DEATH 7mont. MD.

10. CITY OR TOWN OF DEATH SILVER SPRING 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESMAN 12b. KIND OF BUSINESS OR INDUSTRY FURNITURE

13a. STATE MARYLAND 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN SILVER SPRING 14. INSIDE CITY LIMITS? YES ☒ NO ☐ 15. STREET ADDRESS 10013 LORRAINE AVE. Lorain Ave.

14. FATHER'S NAME FIRST MIDDLE LAST ABRAHAM - - - GOLDSTEIN 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MINNIE - - - BRISALOVSKY

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO 16b. SOCIAL SECURITY NO. 579-07-6091 17. INFORMANT ADDRESS ALAN GOLDSTEIN, 4608 AMHERST RD, COLLEGE PARK, MD

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY
(a) 4140 DUE TO, OR AS A CONSEQUENCE OF
(b) Atherosclerotic heart disease
(c) DUE TO, OR AS A CONSEQUENCE OF

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1
Chronic obstructive lung disease, 2 Carcinoma, right lung

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES ☒ NO ☐ 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☒ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ AT WORK NOT WHILE ☐ AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from March 10 1980 to 4-18-80, that (I) (we) last saw the deceased alive on 4-18-80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

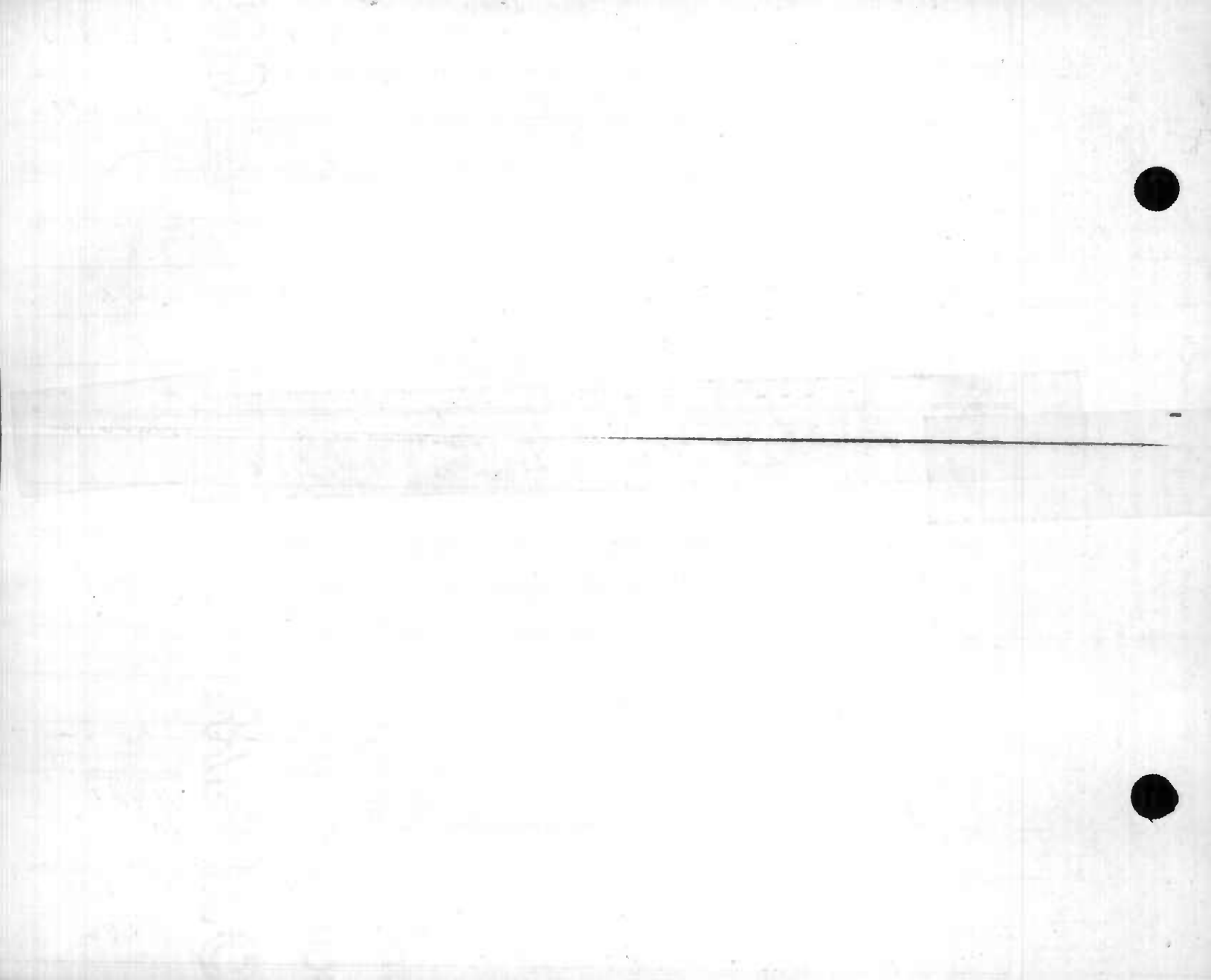
22b. SIGNATURE [Signature] DEGREE 22c. DATE SIGNED 4-18-80

22d. PHYSICIAN'S NAME (TYPE OR PRINT) JASON BEIGER, M.D. 22e. ADDRESS 8P30 CAMERON STREET SILVER SPRING, MD. 20910

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL 23b. DATE 4/21/80 23c. NAME OF CEMETERY OR CREMATORY KING DAVID MEM. GARDEN 23d. LOCATION CITY OR TOWN COUNTY STATE FALLS CHURCH, VIRGINIA

24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEM. CHAPELS, ROCKVILLE, MD. ADDRESS

25a. DAY REG'D. BY REGISTRAR APR 24 1980 25b. REGISTRAR'S SIGNATURE [Signature]



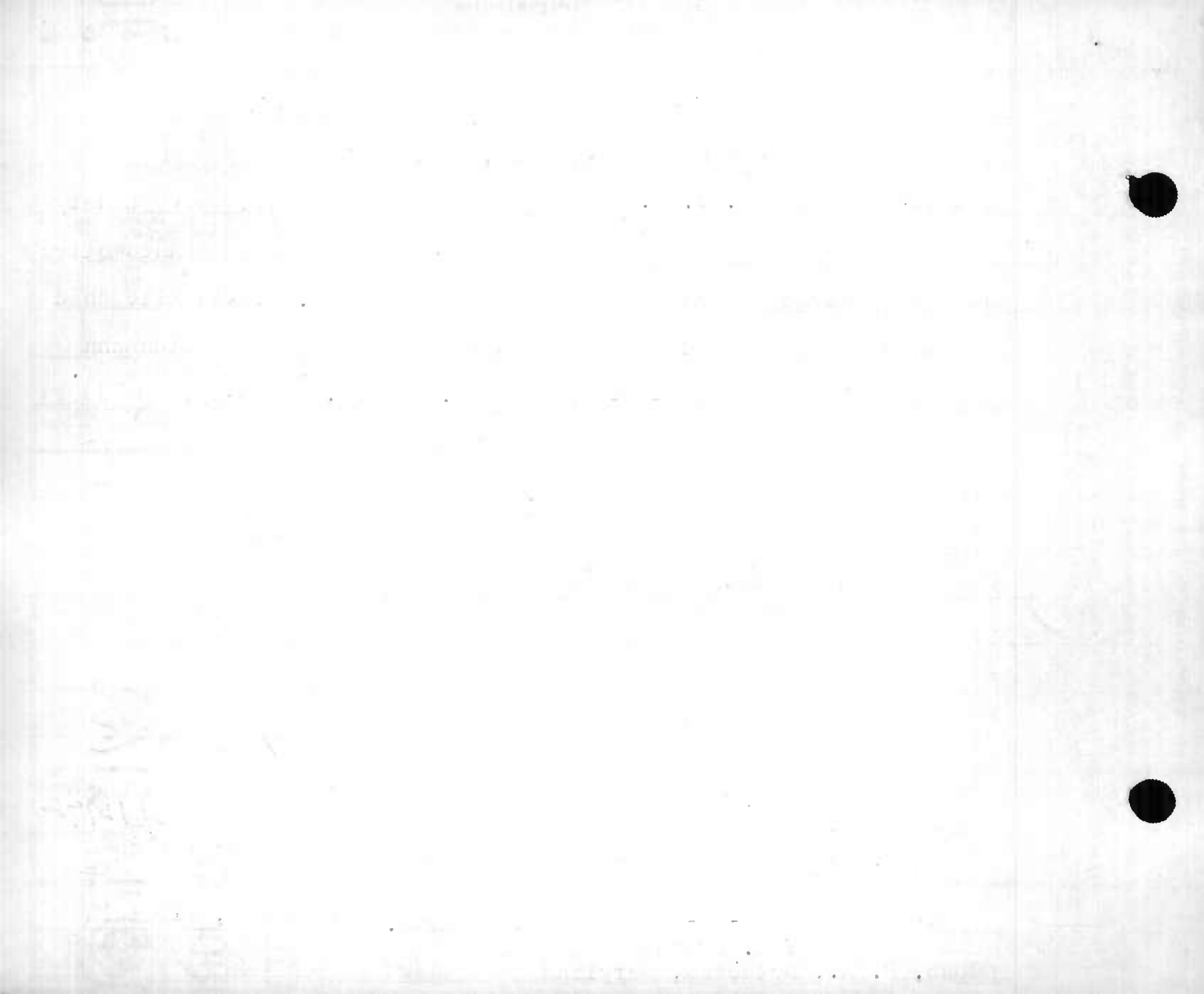
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 0 1 0 6 6 0 | | | |
|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) ETHEL S. Goodnough | | | | 2a. DATE OF DEATH MONTH DAY YEAR April 12, 1980 | | | |
| 3 SEX Female | | 4 RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR April 15, 1895 | | 6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Colorado | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD | |
| 10. CITY OR TOWN OF DEATH Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor | | 12b. KIND OF BUSINESS OR INDUSTRY Automotive | |
| 13a. STATE Michigan | | 13b. COUNTY Wayne | | 13c. CITY OR TOWN Royal Oak | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Alvin Scheffel | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Johanna Weidemann | | 16. STREET ADDRESS 333 E. Eleven Mile Road | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 364-10-8920 | | 17. INFORMANT Joan A. Piemme, Bethesda, MD 20014 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Cardiac Arrest
4280
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Approx
(c) Long Congestive Heart Failure | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 weeks |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Diabetes Mellitus | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that we (this hospital) attended the deceased from April 11, 1980 to April 12, 1980 , that we (we) last saw the deceased alive on April 11, 1980 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above we (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE W.H. Killay MD DEGREE MD | | | | 22c. DATE SIGNED April 14, 1980 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) W.H. Killay MD FOR J.B. Fitzgerald MD | | | | 22e. ADDRESS 6818 Wisconsin Ave Bethesda MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 4-12-80 | | 23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia | |
| 24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P. A., Bethesda, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR APR 16 1980 | | 25b. REGISTRAR'S SIGNATURE Robert A. Pumphrey | |

BP

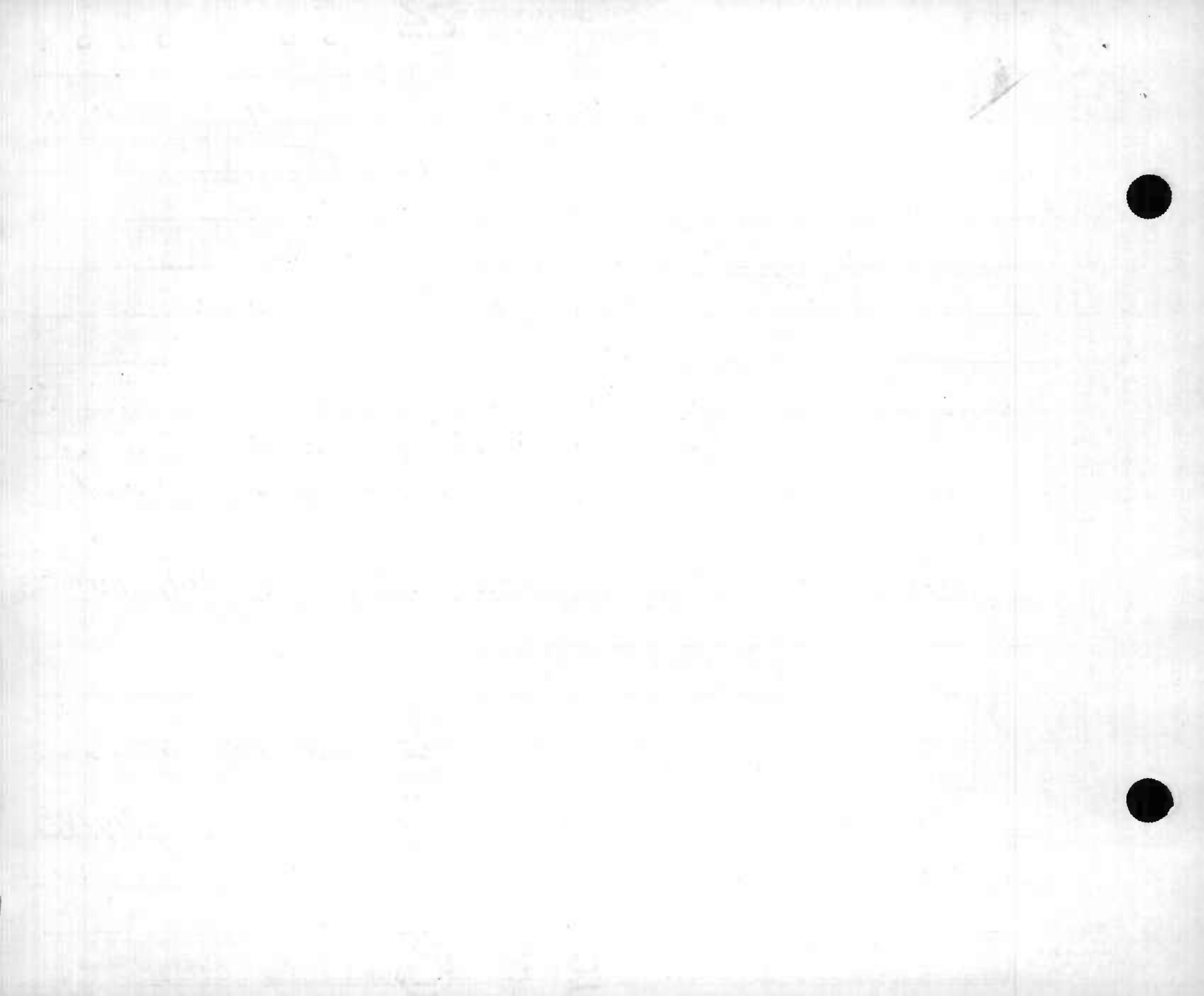


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| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO.
80 10661 | |
|--|--|---|--|---|--|--|--|--|--|----------------------|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
CHLOE P GRABER | | | | 2a. DATE OF DEATH MONTH DAY YEAR
4 13 80 | | 2b. HOUR
10:15AM | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
8 27 04 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Secretary | | 12b. KIND OF BUSINESS OR INDUSTRY
Retired | | | |
| 13a. STATE
Md. | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Sil. Spr. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
10511 Bucknell Drive | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
James M. Pangle | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Lena D. Guard | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | | | | | | |
| 16b. SOCIAL SECURITY NO.
578-07-3108 | | 17. INFORMANT ADDRESS
Mrs. Maxwell Mathews Sil. Spr., Md. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio Respiratory Arrest
436-
DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Vascular Accident
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
mins
Weeks | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Right Lower Lobe Pneumonia; Suspected Bacteriogenic Cerebral Metastasis | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/>
AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from April 13, 1980, to April 13, 1980, that (we) last saw the deceased alive on April 13, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (and) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Harold W. Draper M.D. | | DEGREE
M.D. | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
4/14/80 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HAROLD W. DRAPER M.D. | | 22e. ADDRESS
9801 GEORGIA AVE, Silver Spring Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
4/16/80 | | 23c. NAME OF CEMETERY OR CREMATORY
Green Hill Cemetery | | 23d. LOCATION CITY OR TOWN
Stevens City | | 23e. COUNTY
Va. | | | |
| 24. FUNERAL DIRECTOR NAME
Warner E. Pumphrey, Inc. | | 24b. ADDRESS
8434 Ga. Ave. | | 25a. DATE REC'D. BY REGISTRAR
APR 17 1980 | | 25b. REGISTRAR'S SIGNATURE
P. Kirby McCreedy | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

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| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | 8010662 | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| Elsa C. Grebenstein | | | | 4 | | 9 80 | | 959P ^M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. UNDER 1 YEAR | |
| female | | white | | 12 26 1891 | | 88 | | MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| New York | | USA | | | | Thomontgomery | | Homemaker | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Silver Springs | | Holy Cross Hospital | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| Maryland | | Montgomery | | Silver Springs | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 10,000 Brunswick Avenue | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| C. Henry Grebenstein | | Martha Bernhardt | | no | | 155 32 7541A | | Gaithersburg, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) | | 410- Myocardial infarction | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | 19. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | 19c. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | |
| | | | | | | | | HOUR A.M. MONTH DAY YEAR | |
| | | | | | | | | P.M. 19 | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | Cerebrovascular insufficiency | | 21c. INJURY OCCURRED | | 21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21e. LOCATION | |
| | | | | | | | | STREET CITY OR TOWN COUNTY STATE | |
| | | | | | | | | 79 4-9 80 | |
| | | | | | | | | 22a. I certify that (I) (this hospital) attended the deceased from 4-9-80, to 4-9-80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | |
| | | | | | | | | 22b. SIGNATURE | |
| | | | | | | | | Carroll D. Mahoney | |
| | | | | | | | | 22c. DATE SIGNED | |
| | | | | | | | | 4-10-80 | |
| | | | | | | | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | |
| | | | | | | | | Carroll D. Mahoney | |
| | | | | | | | | 22e. ADDRESS | |
| | | | | | | | | 10301 Georgia Ave. Silver Spring, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | 23e. COUNTY | |
| Burial | | 4/12/80 | | Fairview Cemetery | | Fairview, | | New Jersey | |
| 24. FUNERAL DIRECTOR NAME | | 24b. ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Eaton Wheeler Funeral Home, Inc. | | 1331 Rockville Pike Rockville, Maryland | | APR 15 1980 | | M. J. McCreedy | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8010663 | | | |
|---|--|--|--|---|--|--|--|---|--|-------------------|-----|--|----------|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR |
| IRMA O. Greene | | | | | | | | APRIL 16, 1980 | | | | | 5:30 AM |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | 7 IF UNDER 1 YEAR | | 8 IF UNDER 24 HRS | | | |
| Female | | Black | | Feb 17 1914 | | 66 YRS | | MONTHS | | DAYS | | HOURS | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| South Carolina | | USA | | | | Mont. MD. | | | | | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| | | Chevy Chase Nursing Home | | Retired Gov. Clerk | | | | | | | | | |
| 13a STATE | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? | | 13e STREET ADDRESS | | | | | |
| Maryland | | M. Silver Spring | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 9325 Harvey Road | | | | | |
| 14 FATHER'S NAME | | 15 MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| Soloman Swygert | | Daisy Louie | | | | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT | | 9325 Harvey Road | | | | | | | |
| no | | 578 09 7564 | | Mrs. Carolyn Arrington-daughter- | | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE Cause (a) Congestive heart failure | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 4349 DUE TO, OR AS A CONSEQUENCE OF (b) multiple valvular disease | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOT BY MEDICAL EXAMINER) | | 21b TIME OF INJURY | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | |
| | | P.M. 19 | | | | | | | | | | | |
| 21d INJURY OCCURRED | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION | | | | | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | STREET | | CITY OR TOWN | | COUNTY | | STATE | | | |
| 22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b SIGNATURE | | DEGREE | | 22c DATE SIGNED | | | | | | | | | |
| Alfred S. Lai | | MD | | 4/16/80 | | | | | | | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e ADDRESS | | | | | | | | | | | |
| Alfred Lai MD | | 2141 K St NW, Wash DC | | | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION | | | | | | | |
| Burial | | Apr. 19, 1980 | | Lincoln Memorial | | Suitland, Maryland | | | | | | | |
| 24 FUNERAL DIRECTOR NAME | | 24b DATE REC'D. BY REGISTRAR | | 24c REGISTRAR'S SIGNATURE | | | | | | | | | |
| Stewart Funeral Home-4001 Benning Road, NE. | | APR 22 1980 | | | | | | | | | | | |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4, 5, AND 6 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))
30M 7/73

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 10664 | |
|---|--|---|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 20. DATE OF DEATH | | KNOWN ESTIMATED | | 21. HOUR | |
| | | Margaret Cadwell Gregg | | | | 4 1 19 80 | | | | M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | |
| Female | | White | | 7 6 10 | | 69 YRS. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | WIDOWED | | DIVORCED | |
| Kansas | | USA | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Bethesda | | Suburban Hospital | | Bookeeper | | A/C & Refr. | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| Maryland | | Montgomery | | Bethesda | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 10407 Montrose Avenue | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| John C. Cadwell | | Hazel Jackson | | no | | 470 32 1493 | | Mary Bernardo | | 17200 Edwards Ferry Rd. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Multiple injuries | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (b) | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | |
| | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 6:05 P.M. 4 1 19 80 | | | | pedestrian struck by auto | | | |
| 21d. INJURY OCCURRED | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | Street | | | | Parklawn Dr. east of Washington Ave, Rockville | | | |
| 22a. I certify that I took charge of the remains described above, held on | | | | | | | | | | | |
| Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | |
| death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | |
| Thomas D Smith | | | | Deputy Chief | | | | 4/2/80 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | |
| Thomas D Smith, M.D. | | | | 111 Penn St. Balto., MD. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | |
| Cremation | | | | 4/3/80 | | | | Metropolitan Crematory | | | |
| | | | | | | | | 23d. LOCATION | | | |
| | | | | | | | | CITY OR TOWN | | | |
| | | | | | | | | Alexandria, Virginia | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| NAME | | | | APR 7 1980 | | | | History, McHenry | | | |
| 1331 Rockville Pike Rockville, Maryland | | | | | | | | | | | |

MEDICAL CERTIFICATION

1203



[Faint, mostly illegible text, possibly a ledger or form with multiple columns and rows.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8010665 | | | |
|---|-----------|---|--|--|--|--|--|--|--|------------|-----|------------|----------|
| 1- FOR
STATE
REGISTRAR | | REG. NO. | | | | | | | | | | | |
| 1 DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR |
| HENRY C. MCGREGORY | | | | | | | | April | | 13 | '80 | 10:10 P.M. | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | 7 IF UNDER 1 YEAR | | 8 IF UNDER 72 HRS | | | | | |
| Male | Caucasian | Nov. 2, 1901 | | 78 YRS. | | MONTHS | | DAYS | | HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| West Virginia | | USA | | | | Montgomery MD. | | | | | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | | | | |
| Rockville | | Collingswood Nursing Home | | | | | | | | | | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Teacher - Adm. Education | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | |
| Florida | | Marion | | Ocala | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 2843 N.E. 3rd | | | | | |
| 14 FATHER'S NAME | | 15 MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| William | | Sarah | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17 INFORMANT | | ADDRESS | | | | | | | |
| Yes | | WW II | | 217-18-4878 | | William S. Gregory | | 13029 Scarlet Oak Dr. Gaithersburg, Md. | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic CARCINOMA
1539 } DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA Colon
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
8 months
2 years | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from July 1979 to 4/13/80, that (1) <input checked="" type="checkbox"/> last saw the deceased alive on 4/14/80, and that in (my) last opinion death occurred on the date and hour and from the causes stated above, (1) <input checked="" type="checkbox"/> (did not) view the body after death. | | 22b. SIGNATURE
Thos G. Ward MD | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
4/14/80 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | | | |
| Thos G. WARD | | 6116 ROBINWOOD, Bethesda, Md. 20814 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | | | |
| Burial | | Apr. 17, 1980 | | Parsons Cem. | | Parsons, West Virginia | | | | | | | |
| 24 FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| Robert A. Pumphrey | | APR 17 1980 | | Pumphrey, M. C. Brady | | | | | | | | | |
| Homes, P.A. Bethesda, Md. | | | | | | | | | | | | | |

BP.

| | | | | | | |
|-----|---------------|-------------|------------|-------------|----------------------------|--------------|
| Yes | William | Gregory | William | 217-15-1478 | Gregory William S. Gregory | 12019 Senior |
| | Florida | Marion | Ocala | | | |
| | Rockville | Collinswood | Greenville | | | |
| | West Virginia | USA | | | | |
| | | | | | | |

12019 Senior
 Gregory William S. Gregory
 217-15-1478
 William
 Gregory
 Marion
 Ocala
 Florida
 Rockville
 Collinswood
 Greenville
 West Virginia
 USA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

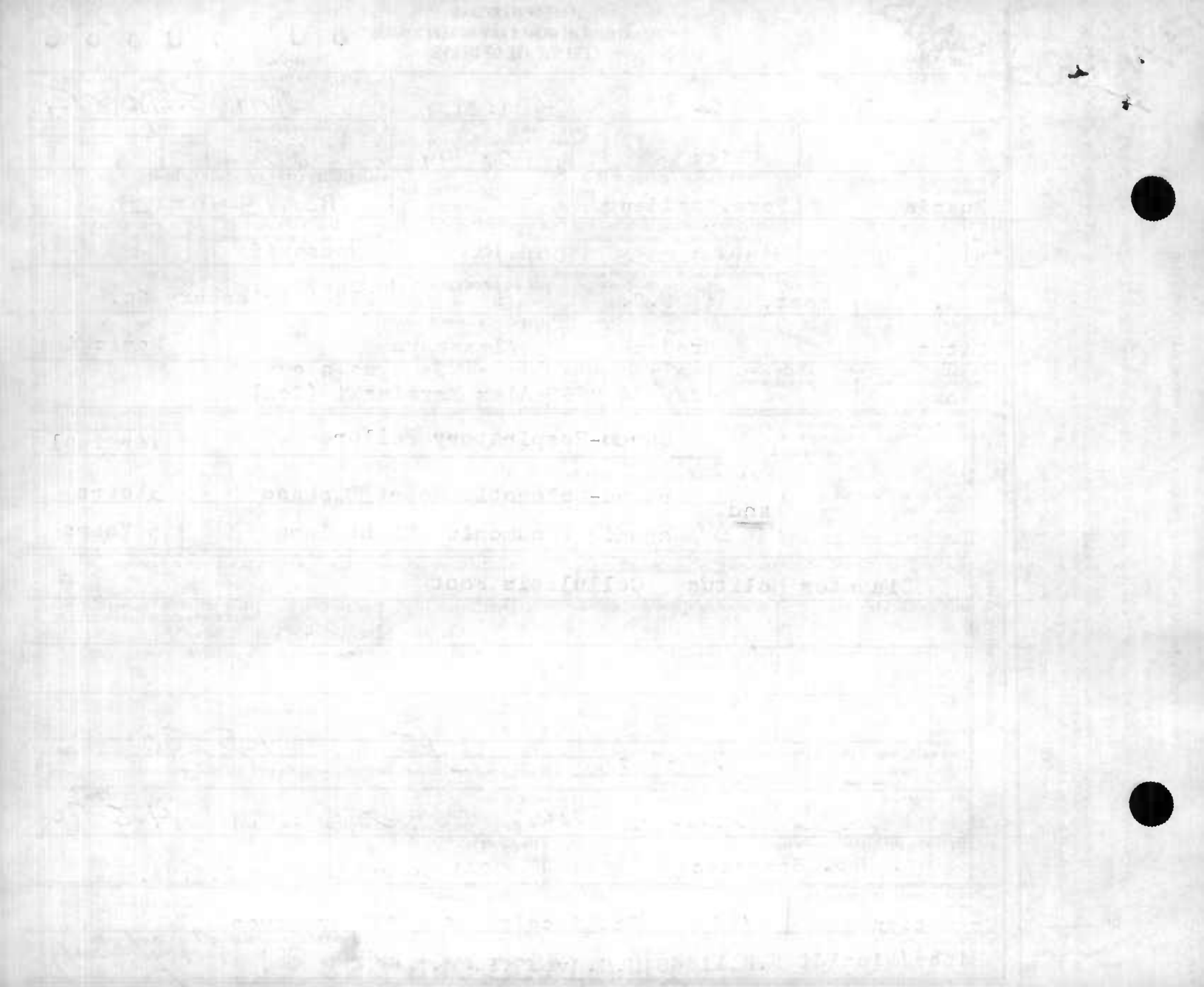
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 1 0 6 6 6
REG. NO.

| | | | | | | | | | | |
|--|--|--|---|--|---|--|--|--|---|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
Janina Grodecka | | | 2a. DATE OF DEATH
MONTH DAY YEAR
April 5 1980 | | | 2b. HOUR
8:45 P.M. | | | | |
| 3 SEX
F | | 4 RACE
White | | 5 DATE OF BIRTH
MONTH DAY YEAR
11 06 94 | | 6 AGE (IN YEARS LAST BIRTHDAY)
85 YRS. | | 7 UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Russia | | 7b CITIZEN OF WHAT COUNTRY?
Perm. Resident | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | |
| 10 CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| 13a STATE
Md. | | | 13b COUNTY
Mont. | | 13c CITY OR TOWN
S.S. | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS
15204 Aylesbury St. | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Titus Grodecka | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Alexandra Novicki | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
None | | | 16b SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
220 54 0553 | | 17 INFORMANT Same as above
Alex Karpinski (Son) | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Cardio-Respiratory Failure | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
Terminal | | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) Artero-Sclerotic Heart Disease | | | | | | | | 5 Years | | |
| and (c) Chronic Pneumonia Right Lung | | | | | | | | 5 Years | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
Diabetes Melitus Cellulitis Foot | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a I certify that (b) (this hospital) attended the deceased from 19 65 to 4-5 19 80, that (b) (the) lost saw the deceased alive on 4-5 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (the) (did not) view the body after death. | | | | | | | | | | |
| 22b SIGNATURE
Dr. Geo. Sengstack | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c DATE SIGNED
4-5-80 | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Geo. Sengstack | | | | | | 22e ADDRESS
9241 Columbia Pike S.S.Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | | 23b. DATE
4/9/80 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Crematory Brentwood | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
PG Md. | | | |
| 24 FUNERAL DIRECTOR
Hines/Rinaldi F.H.11800 N.H.Ave.S.S.Md. | | | | | | 25a. DATE REC'D BY REGISTRAR
APR 11 1980 | | | | |



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|--|--|--|---|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Harry Ralph Gue | | | 2a. DATE OF DEATH
MONTH 04 DAY 08 YEAR 80 | | | 2b. HOUR
10:35 | | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH Dec. DAY 12 YEAR 1921 | | 6. AGE (IN YEARS LAST BIRTHDAY)
58 YRS | | 7. IF UNDER 1 YEAR
MONTHS 00 DAYS 00 | | 7b. IF UNDER 24 HRS
HOURS 00 MIN 00 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | | | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery Gen. Hosp., Olney | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Fire Chief | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Gov't | | | |
| 13a. STATE
Maryland | | | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Damascus | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST Harry MIDDLE C. LAST Gue | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST Sallie MIDDLE A. LAST Poole | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | | | 16b. SOCIAL SECURITY NO.
W.W. 2 214-16-7956 | | 17. INFORMANT
ADDRESS Betty A. Gue, Item 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Renal Cell Carcinoma metastatic
1890
DUE TO, OR AS A CONSEQUENCE OF (b) to both lungs.
DUE TO, OR AS A CONSEQUENCE OF (c) And
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
Mediastinal + Orbital metastases. Bronchopneumonia, Heart failure | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Apr 79 , to 8 Apr 80 , that (I) (we) last saw the deceased alive on 8 Apr 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Donald E. Dillon | | | | | | DEGREE
M.D. | | 22c. DATE SIGNED
9 Apr 80 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Donald E. Dillon, M.D. | | | | | | 22e. ADDRESS
1811 Pr. Philip Dr Olney, Md 20832 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
Apr. 11, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY
Damascus Meth. | | 23d. LOCATION
CITY OR TOWN Damascus, Montgomery, Md. COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR
NAME Olin L. Molesworth, Damascus, Md. ADDRESS | | | | | | 25a. DATE REC'D. BY REGISTRAR
APR 15 1980 | | 25b. REGISTRAR'S SIGNATURE
Harry McCreedy | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

John L. Holmworth, Danvers, Me.

1951, 11. 7

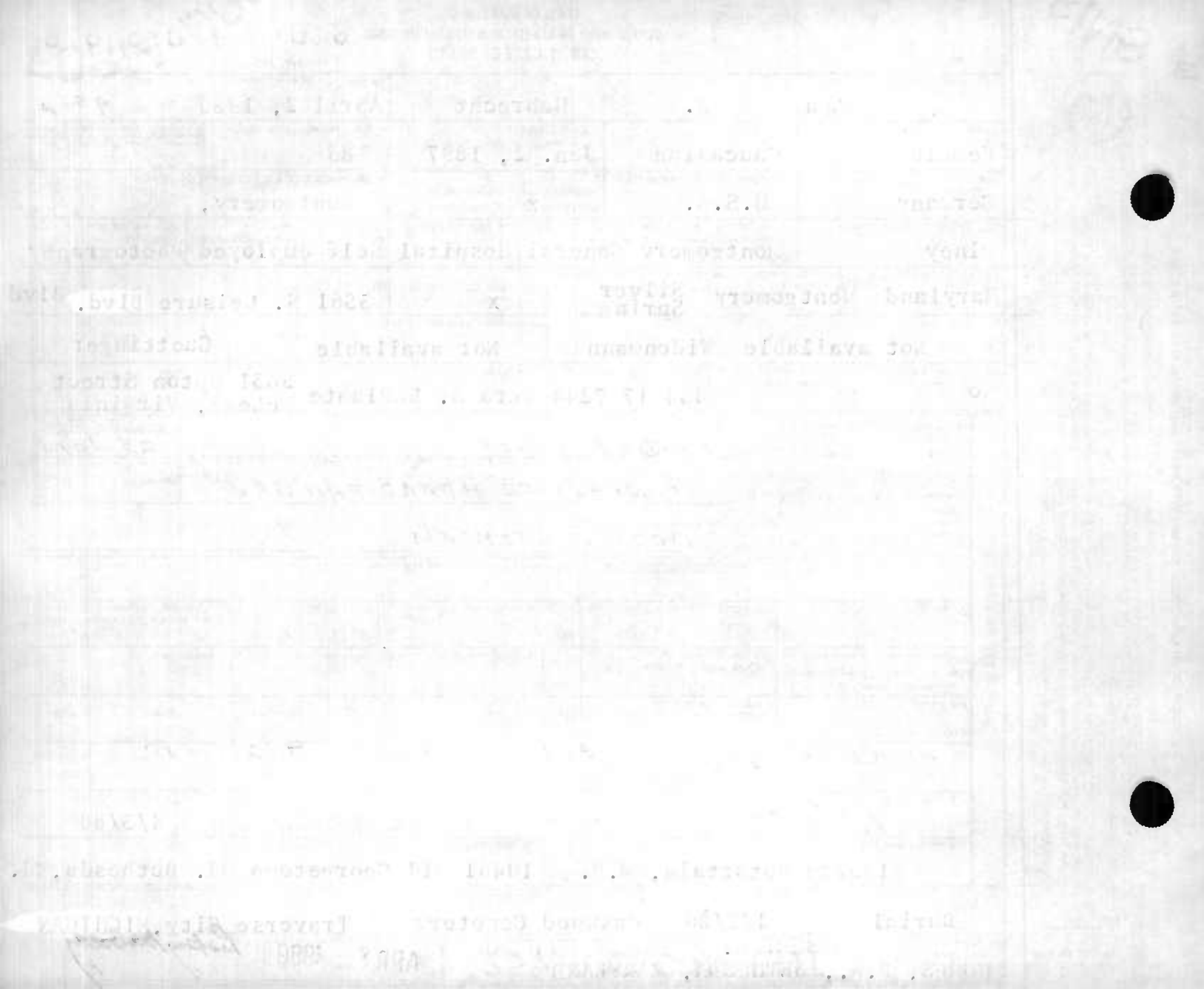
• 1990 •

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 0 1 0 6 6 8 | |
|--|--|--|--|---|--|--|--|---|--|--|--|
| 1. FOR
STATE
REGISTRAR | | | REG. NO. | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST
Maya B. Habrecht | | | 2a. DATE OF DEATH MONTH DAY YEAR
April 2, 1980 | | | 2b. HOUR
955 PM | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
Jan. 2, 1897 | | 6. AGE (IN YEARS LAST BIRTHDAY)
83 YRS | | 7. UNDER 1 YEAR
MONTHS DAYS | | 7b. UNDER 74 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Germany | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Self employed | | 12b. KIND OF BUSINESS OR INDUSTRY
Photography | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MARYLAND 13b. COUNTY Montgomery 13c. CITY OR TOWN Spring | | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3561 S. Leisure World Blvd | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Not available Widenmann | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Not available Guettinger | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
454 17 7244 | | 17. INFORMANT
Vera S. LaPlante | | ADDRESS
5831 Upton Street
McLean, Virginia | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARNAL SHOCK.</u>
<u>4241</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>CONGESTIVE HEART FAILURE</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>AORTIC STENOSIS</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>25 days</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/9</u> , 19 <u>80</u> , to <u>4/2</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>4/2</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Alberto Rotsztain</u>
M.D. | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
4/3/80 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Alberto Rotsztain, M.D. | | | | | | 22e. ADDRESS
10401 Old Georgetown Rd. Bethesda, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
4/5/80 | | 23c. NAME OF CEMETERY OR CREMATORY
Oakwood Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Traverse City, Michigan | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND | | | | | | 25a. DATE REC'D. BY REGISTRAR
APR 8 1980 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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6002 BP

DHMM-16 25M
(VRA 15, 4) 1/79

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 1 0 6 6 9

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|---|---|---|--|--|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
Gladys Cotton Davis Halnon | | | 2a. DATE OF DEATH MONTH DAY YEAR
April 26, 1980 | | | 2b. HOUR
3:45 PM | |
| 3 SEX
Female | 4 RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
11/12/1898 | | 6. AGE (IN YEARS LAST BIRTHDAY)
81 YRS. | # UNDER 1 YEAR
MONTHS DAYS
0 0 | | # UNDER 24 HRS
HOURS MIN.
0 0 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Connecticut | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | | | |
| 10. CITY OR TOWN OF DEATH
Kensington | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Circle Manor Nursing Home | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Potomac | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
10307 Riverwood Drive |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Wilbur Fiske Cotton | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sarah Ida B. Leete | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
049-09-4799 | | 17. INFORMANT
ADDRESS
Beverly D. Sceery, same as #13 | | | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Arrest | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF
(b) Probable Sepsis. | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) Decubitus Ulcers. | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | | | |
|--|--|--|--|--|---|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from ~ Dec. 1977 to 4-26, 1980 , that (I) (we) last saw the deceased alive on ~ 4-17, 1980 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Christopher Unger | | DEGREE | | 22c. DATE SIGNED
4-26-80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Christopher Unger, M.D. | | 22e. ADDRESS
7801 Moorland Lane, Bethesda, Md. | | | |

| | | | |
|---|-----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
4/29/80 | 23c. NAME OF CEMETERY OR CREMATORY
Fairview Cemetery | 23d. LOCATION
CITY OR TOWN COUNTY STATE
New Britain, Connecticut |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND | | 25a. DATE REC'D. BY REGISTRAR
MAY 1 1980 | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8010670 | |
|---|--|--|--|--|--|--|--|--|---|--|--|
| 1. FOR
STATE
REGISTRAR | | REG. NO. | | | | | | | | | |
| 1 DECEASED NAME
(TYPE OR PRINT)
Merle L. Harding | | | | | 2a DATE OF DEATH
MONTH DAY YEAR
APRIL 29 1980 | | | 2b HOUR
5 25 AM | | | |
| 3 SEX
Male | | 4 RACE
White | | 5 DATE OF BIRTH
MONTH DAY YEAR
Dec. 19 1922 | | 6 AGE (IN YEARS LAST BIRTHDAY)
57 YRS. | | 7a IF UNDER 1 YEAR
MONTHS DAYS | | 7b IF UNDER 24 HRS
HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington, DC | | 7b CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10 CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Machinist | | 12b KIND OF BUSINESS OR INDUSTRY
U.S. Govt. | | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE 13b COUNTY
Maryland Montgomery | | | | | 13c CITY OR TOWN
Sil. Spring | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS
613 Wayne Avenue, | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Elmer L. Harding | | | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Grace Mullican | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
yes | | | | | 16b SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WWII 217-18-7838 | | 17 INFORMANT (sister) ADDRESS
Dorothy Williams- Port Republic, Md. | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>upper GI Hemorrhage</u>
5715
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) <u>Esophageal Varices</u>
(c) <u>Cerebral Ischemia</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
8 days | |
| | | | | | | | | | | 5 days | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a DATE OF OPERATION
4/28/80 | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED
Bleeding esophageal varices | | | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>April 28</u> , 19 <u>80</u> , to <u>April 29</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>April 28</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b SIGNATURE
Sydney Leventhal, M.D. | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c DATE SIGNED
4/29/80 | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
Sydney Leventhal, M.D. | | | | | | 22e ADDRESS
Silver Spring Md. 20910. | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b DATE
May 1, 1980 | | 23c NAME OF CEMETERY OR CREMATORY
Cheltenham | | | 23d LOCATION
CITY OR TOWN COUNTY STATE
Cheltenham Pr. Georges Md | | | |
| 24 FUNERAL DIRECTOR
Walter E. Pumphrey, Inc.
8434 Ga. Ave., S.S. Md. | | | | | | 25a DATE RECD. BY REGISTRAR 25b REGISTRAR'S SIGNATURE
MAY 5 1980 [Signature] | | | | | |

Wm. B. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 1 0 6 7 1

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | |
|---|-------------------------|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
<i>Melvin Oden Hardy</i> | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>4/3/80</i> | | 2b. HOUR
AM PM
<i>4:33 AM</i> | |
| 3. SEX
<i>Male</i> | 4. RACE
<i>White</i> | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>3-19-14</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS
<i>66</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Washington D C</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U S A</i> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery</i> MD. | |
| 10. CITY OR TOWN OF DEATH
<i>Takoma Park</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Washington Adventist Hospital</i> | | 12b. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Carpenter</i> | |
| 13a. STATE
<i>Md</i> | | 13b. CITY OR TOWN
<i>Pro Georges Hyattsville</i> | | 13c. STREET ADDRESS
<i>6101 42nd avenue</i> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Rufus Hardy</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Matilda Burgess</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>no</i> | | 16b. SOCIAL SECURITY NO.
<i>579 07 8508</i> | | 17. INFORMANT
ADDRESS
<i>William Hardy Washington D C</i> | |

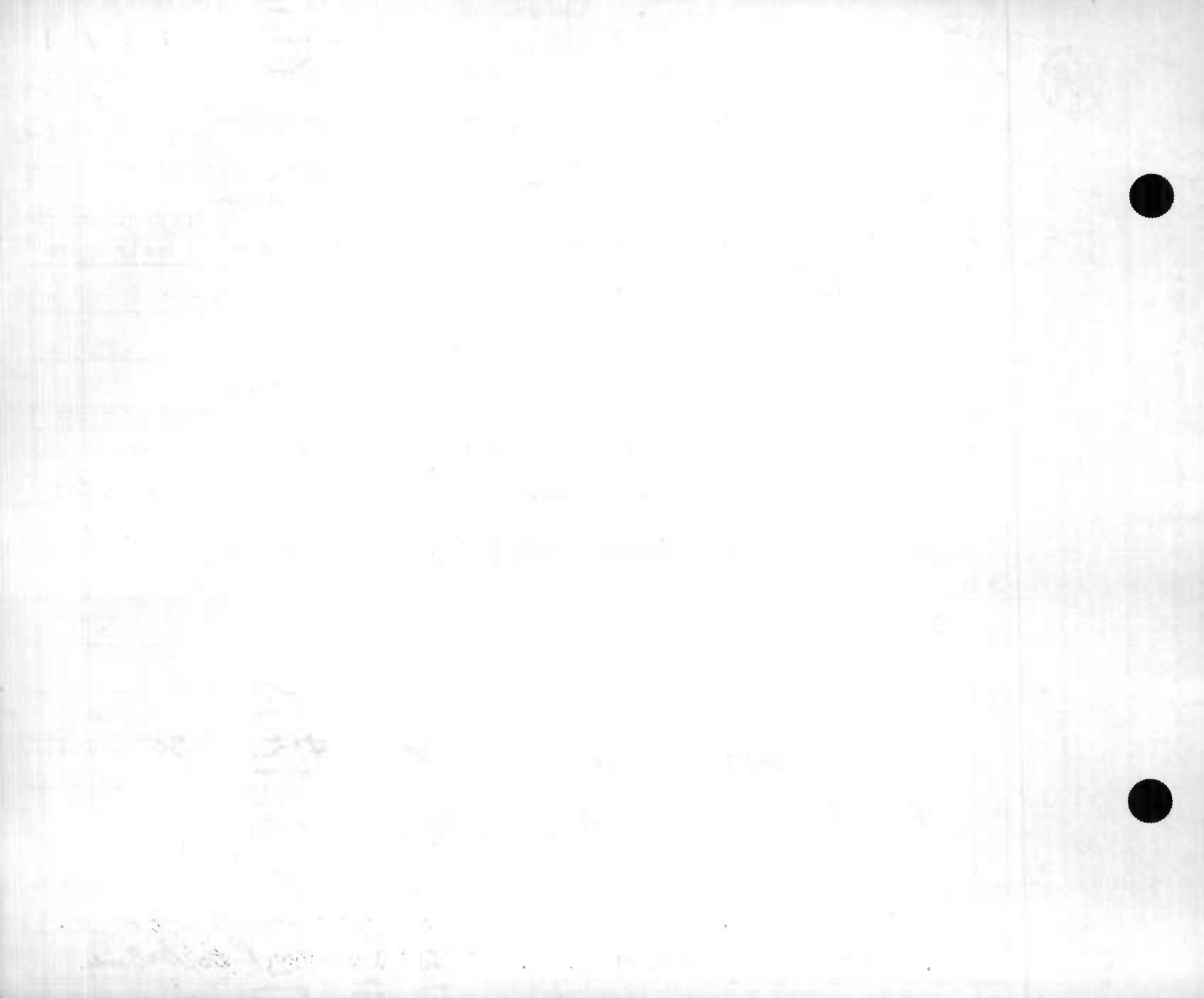
| | | |
|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardiorespiratory Failure</i> | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<i>20 minutes</i> |
| Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.
<i>1481</i> | DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Obstruction of larynx</i> | <i>3 months</i> |
| | DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Carcinoma of Paranasal Sinus</i> | <i>months</i> |

| | | | |
|---|--|--|---|
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | |
| 19a. DATE OF OPERATION
<i>3-19-80</i> | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>Obstruction of larynx</i> | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>4/2</i> 19 <i>80</i> to <i>4/3</i> 19 <i>80</i> , that (I) (we) lost
saw the deceased alive on <i>4/2</i> 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
<i>W W Eastman</i> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>W W Eastman</i> | | 22e. ADDRESS
<i>Silver Springs, Md</i> | |

| | | | |
|---|---------------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | 23b. DATE
<i>Apr 5, 1980</i> | 23c. NAME OF CEMETERY OR CREMATORY
<i>Ft Lincoln Cemetery</i> | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Brentwood Pro Georges Md.</i> |
| 24. FUNERAL DIRECTOR
NAME
<i>F. Gasch's Sons P A Hyattsville, Md.</i> | | 25a. DATE REC'D. BY REGISTRAR
<i>APR 7 1980</i> | 25b. REGISTRAR'S SIGNATURE
<i>Henry McCreedy</i> |

BP

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(VRA 15, 4) 7/78



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8010672 | | | |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1 DECEASED NAME
(TYPE OR PRINT) Elizabeth Dodson Harrison | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
4 15 80 | | 2b. HOUR
MIN
5:25 A | |
| 3 SEX
Female | | 4 RACE
Cau | | 5 DATE OF BIRTH
MONTH DAY YEAR
August 16 1895 | | 6 AGE (IN YEARS LAST BIRTHDAY)
84 YRS. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10 CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b KIND OF BUSINESS OR INDUSTRY
Own Home | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE
Maryland | | | | 13b COUNTY
Montgomery | | 13c CITY OR TOWN
Rockville | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Will Dodson | | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ella Taylor | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b SOCIAL SECURITY NO
(IF YES, GIVE WAR OR DATES)
N/A | | 17 INFORMANT
NAME ADDRESS
Son - Charles Harrison
1617 Lewis Ave., Rockville, Md. 20851 | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1: DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) cardio-pulmonary failure
2765
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
(b) Dehydration, old age, Parkinson's disease
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
few hrs | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a DATE OF OPERATION
/ | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED
/ | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22. I certify that (I) (this hospital) attended the deceased from February 19 80 , to 4-15 19 80 , that (I) (we) lost
saw the deceased alive on 4-14 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 27b SIGNATURE
Frankie Wehrhane M.D. | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 27c DATE SIGNED
4-15-1980 | |
| 27d PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 27e ADDRESS | | | |
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b DATE
Apr 18 80 | | 23c NAME OF CEMETERY OR CREMATORY
National Memorial Park | | 23d LOCATION
CITY OR TOWN COUNTY STATE
Falls Church Va. | |
| 24 FUNERAL DIRECTOR
NAME ADDRESS
Demaine Funeral Homes, Inc. Alexandria, Va. | | | | 25 DATE REC'D. BY REGISTRAR
APR 22 1980 | | 25b REGISTRAR'S SIGNATURE
notary m. c. c. c. | |

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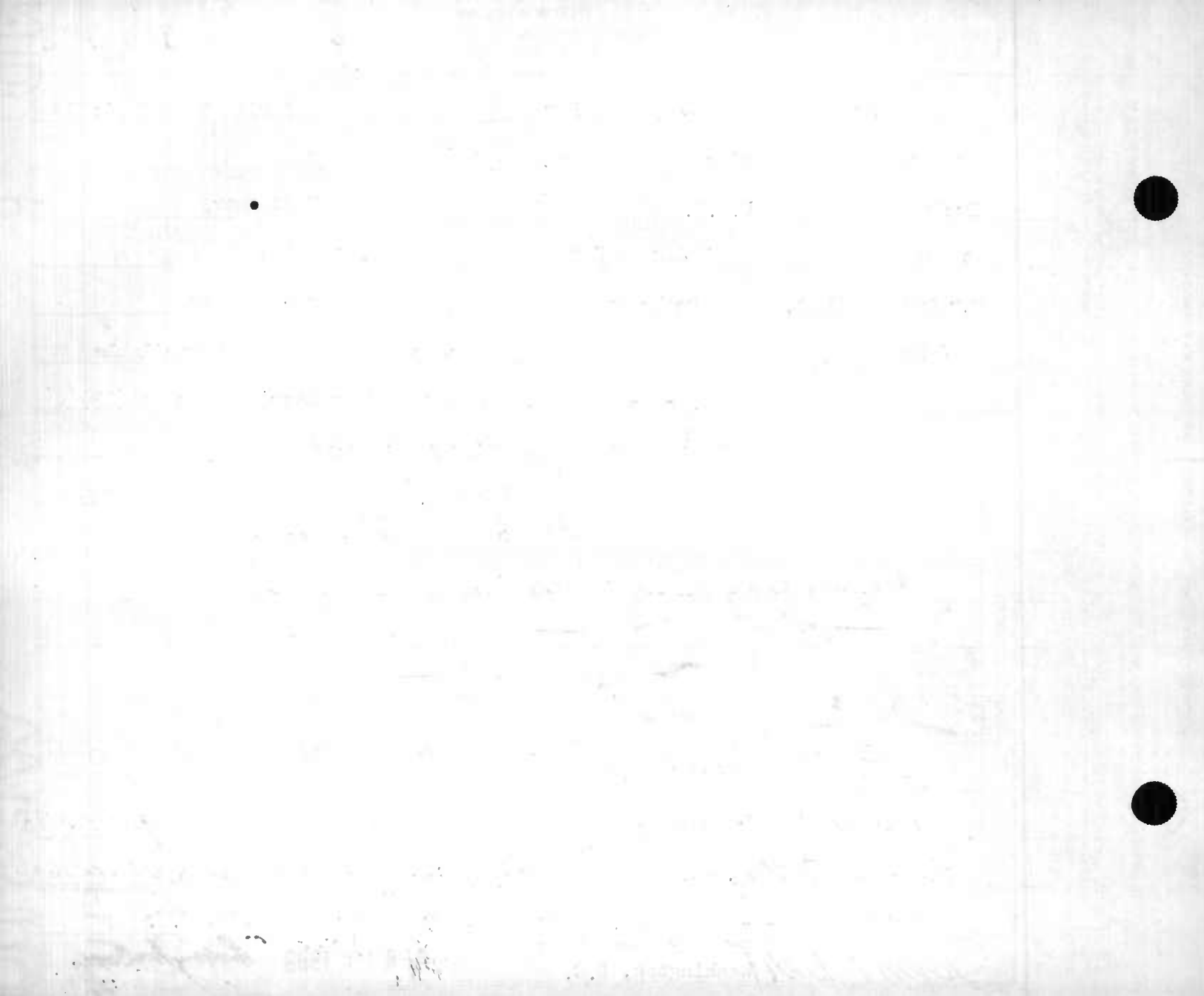
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| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8010673 | |
|---|--|---|-------------------|--|--|--|--|---|----------|--|--|
| 1 - FOR
STATE
REGISTRAR | | | REG. NO. | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | MONTH DAY YEAR | | | 2b. HOUR | | |
| Helena (NONE) Hart | | | April 7 1980 | | | | | | 6:30 AM | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (IN YEARS (LAST BIRTHDAY)) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| Female | | White | | MONTH DAY YEAR
Oct. 8 1887 | | 92 YRS | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Ireland | | U.S.A. | | | | Montgomery MD | | | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Bethesda | | 5508 Jordan Road | | | | Housewife | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| Maryland | | Mont. | | Bethesda | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 5508 Jordan Road | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| FIRST MIDDLE LAST
John Wallace | | | | FIRST MIDDLE LAST
Margaret unavailable | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | 17. INFORMANT | | | | ADDRESS | |
| No | | | | 095-42-0380 | | Ann Mae Ryan (daughter) | | | | same as (13) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Central Respiratory Failure</u>
436-
DUE TO, OR AS A CONSEQUENCE OF <u>Cerebrovascular Accident</u>
(b) <u>Cerebral Arteriosclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF <u>Cerebral Arteriosclerosis</u>
(c) <u>Coronary Artery Disease & Right Bundle Branch Block</u> | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
5 days. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from <u>June</u> 19 <u>74</u> to <u>April 7</u> 19 <u>80</u> , that (1) (we) lost
saw the deceased alive on <u>April 3</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above (a) (b) (c) (d) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Richard J. Meyer</u> | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>April 8, 1980</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>RICHARD J. MEYER</u> | | | | | | 22e. ADDRESS
<u>4731 MASS. AVE. NW WASH DC 20016</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | 4-9-80 | | St. Peters Cemetery | | Poughkeepsie, N.Y. | | | | | |
| 24. FUNERAL DIRECTOR
NAME <u>John E. DeVol</u> ADDRESS <u>Funeral Home Washington, D.C.</u> | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE
<u>Antony Anthony</u> | | | |
| | | | | | | APR 10 1980 | | | | | |

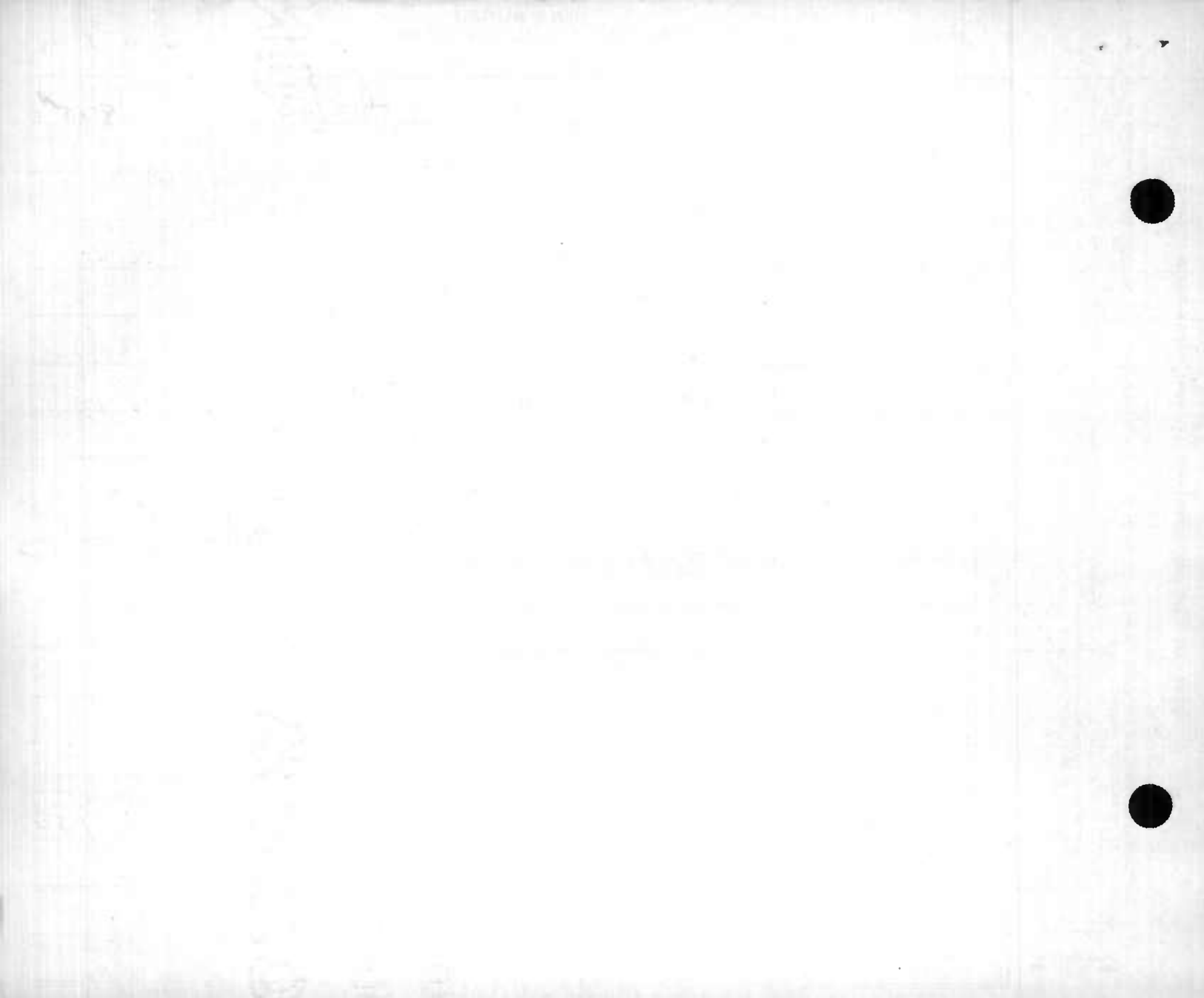


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| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 0 1 0 6 7 4 | | | |
|---|--|------------------------------|---|---|------------------------------------|--|--------------------------------------|--|--------------------------------------|---|----------|-----------------|--|
| 1. FOR
STATE
REGISTRAR | | | REG. NO. | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE OF DEATH | | | MONTH DAY YEAR | | 2b. HOUR | | |
| Margaret S. Hasker | | | | | | 4/15/80 | | | | | 8:15 AM | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| Female | | White | | MONTH DAY YEAR
10 2 1896 | | | 83 YRS | | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | |
| Md. | | U.S.A. | | | | | Montgomery MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Rockville | | | 14643 Bauer Drive | | | Housewife | | | Own Home | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | |
| Md. | | Montgomery | | Rockville | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 14643 Bauer Drive | | | | | |
| 14. FATHER'S NAME | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| FIRST MIDDLE LAST | | | | | | FIRST MIDDLE LAST | | | | | | | |
| Benjamin Fowler | | | | | | Rhoda Shaw | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | 17. INFORMANT | | | ADDRESS | | | | |
| No | | | | 579-68-4545 | | L. Rosetta Lynch | | | 2501 Shanandale Dr
Sil. Spr., Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | |
| IMMEDIATE CAUSE (a) <u>Cardiopulmonary failure</u> | | | | | | | | | | min. | | | |
| 4409 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sen. Arteriosclerosis</u> | | | | | | | | | | years. | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Renal & cardiac failure</u> | | | | | | | | | | months | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| | | | P.M. 19 | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION | | | | | | | |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | | | CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>April 8</u> , 19 <u>80</u> , to <u>present</u> , 19 <u>80</u> , that (I) (we) lost
saw the deceased die on <u>April 8</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) did not view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED | | | | |
| <u>Abraham W. Danish, MD</u> | | | | | | | | | 4/15/80 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | | | | | | | | |
| Abraham W. Danish, MD | | | 1106 Spring, Street Sil. Spr., Md. | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | | 4/17/80 | | Arlington National | | | Arlington, Virginia | | | | | |
| 24. FUNERAL DIRECTOR
NAME | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| Warner E. Pumphrey, Inc. | | | 8434 Ga. Ave. | | | APR 17 1980 | | | | | | | |
| | | | Sil. Spr., Md. | | | | | | | | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | | | | |
|---|---------|---|--|---|----------------|---|------------------|---|--------------------------|---------------------|----------------|--|------------------|----|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | | | |
| Lula C. Hawkins | | | | | | | | X Apr. 11, 1980 | | | | 10 ^{AM} | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | MONTH DAY YEAR | | 2d. HOUR | | |
| Female | Black | 10-25-11 | | 68 | | | | | April 11, 1980 | | | | 12 ^{PM} | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | MD | |
| Md. | | U.S.A. | | | | | | MONTGOMERY | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| Rockville | | 725 N. Horners Lane | | | | | | | | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | | | | |
| | | Md. | | Montg. | | Rockville | | | | 725 N. Horners Lane | | | | | |
| 14. FATHER'S NAME | | MIDDLE | | LAST | | 15. MOTHER'S MAIDEN NAME | | FIRST | | MIDDLE | | LAST | | | |
| Charles Booz | | | | | | Isabell Diggs | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | |
| No | | 218-24-2973 | | Helen Hawkins (Daughter) | | same as #13 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute.</u>
411-
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) <u>Cardio-Vascular Disease.</u>
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
<u>Diabetes Mellitus</u> | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | | | | | | | | | | | |
| John S. Ball | | M.D. Deputy | | April 11, 1980 | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | | | | | | | | | |
| Burial | | 34-15-80 | | Lincoln Park Cemetery | | Rockville, Montg. Md. | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | 24b. ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| George R. Snowden | | 246 N. Washington Street Rockville, Md. 20850 | | APR 17 1980 | | M. J. McCreedy | | | | | | | | | |

1-11-11
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1-11-11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified on

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|--|--|--|--|--|--|--|----------------------------|--|--|
| 1. FOR STATE REGISTRAR | | I. DECEASED NAME (TYPE OR PRINT)
Nellie Lee Hawkins | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
APRIL 6, 1980 | | 2b. HOUR
1:30 P.M. | |
| 3 SEX
female | | 4 RACE
white | | 5 DATE OF BIRTH
MONTH DAY YEAR
11 27 19 | | 6 AGE (IN YEARS LAST BIRTHDAY)
60 YRS. | | 7 UNDER 1 YEAR
MONTHS DAYS | | 7 UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
West Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10 CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
13204 Twinbrook Parkway | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | | | | 13b. CITY OR TOWN
Montgomery | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS
13204 Twinbrook Parkway | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
James W. Windland | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ione Pennybacker | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
233 26 2510 | | 17 INFORMANT
ADDRESS
Olney, Maryland
Wm. R. Hawkins 3371 Tidewater Ct. | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>CORONARY ARTERY DISEASE - ACUTE INFARCTION</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<u>DIABETES, SCITIZOPHRENIA</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>7/29</u> , 19 <u>79</u> , to <u>3/7</u> , 19 <u>80</u> , that (1) (we) last saw the deceased alive on <u>3/7/80</u> , 19 <u>80</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did <input checked="" type="checkbox"/> did not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Ralph M. Coan M.D.</u>
DEGREE | | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
4/3/80 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Ralph Coan | | | | | | 22e. ADDRESS
4400 East West Highway, Bethesda, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
4/6/80 | | 23c. NAME OF CEMETERY OR CREMATORY
Lakeview Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Victoria, Virginia | | | | | |
| 24 FUNERAL DIRECTOR
NAME
Tyson Wheeler Funeral Home, Inc.
1331 Rockville, Pike Rockville, Md. 208 | | | | | | 25a. DATE REC'D. BY REGISTRAR
APR 7 1980 | | 25b. REGISTRAR'S SIGNATURE
<u>Pitney</u> | | | |

1944, 1945, 1946, 1947, 1948, 1949, 1950, 1951, 1952, 1953, 1954, 1955, 1956, 1957, 1958, 1959, 1960, 1961, 1962, 1963, 1964, 1965, 1966, 1967, 1968, 1969, 1970, 1971, 1972, 1973, 1974, 1975, 1976, 1977, 1978, 1979, 1980, 1981, 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 26

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8010677 | | | |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) CLARENCE R HEATH | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
4 4 80 | | 2b. HOUR
11:50 AM | |
| 3. SEX
MALE | | 4. RACE
W | | 5. DATE OF BIRTH
MONTH DAY YEAR
4 25 22 | | 6. AGE (IN YEARS LAST BIRTHDAY)
57 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
UTAH | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
HOLY CROSS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
DRIVER | | 12b. KIND OF BUSINESS OR INDUSTRY
MESSENGER SERVI | |
| 13a. STATE
MD | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
SILVER SPRING | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
CLARENCE R. HEATH SR. | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
GLADYS HYDEN | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
YES WWII | | 16b. SOCIAL SECURITY NO.
529-07-9895 | |
| 17. INFORMANT
BETTY A. HEATH- SAME AS 13E | | | | 17. ADDRESS
10106 GREELEV AVE | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) gastrointestinal hemorrhage
1419
DUE TO, OR AS A CONSEQUENCE OF
(b) status post therapy for Carcinoma of Tongue
DUE TO, OR AS A CONSEQUENCE OF
(c) marked bilateral pneumonitis | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/4 80 to 4/4 80 , that (I) (we) last saw the deceased alive on 4/4 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
G. Lennard Gold, M.D. | | | | DEGREE
M.D. | | 22c. DATE SIGNED
4/5/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
G. LENNARD GOLD | | | | 22e. ADDRESS
8630 FENTON ST. SILVER SPRING, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
CREMATION | | 23b. DATE
4-6-80 | | 23c. NAME OF CEMETERY OR CREMATORY
METROPOLITAN | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ALEXANDRIA VA. | |
| 24. FUNERAL DIRECTOR
FRANCIS J. COLLINS | | | | 25a. DATE REC'D. BY REGISTRAR
APR 9 1980 | | 25b. REGISTRAR'S SIGNATURE
Barbara McCreedy | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|---|--|--------|--|--|--|-----------------------------------|--|------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR | MIN. | |
| FLORENCE | | | | HELM | APRIL 22, 1980 | | | | 9:06AM | | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | | |
| Female | White | Dec. 31 1886 | | 93 YRS. | MONTHS | | DAYS | | HOURS MIN. | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Missouri | U.S.A. | | | Montgomery MD. | | | | | | | |
| 10 CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Bethesda | Suburban Hospital | | | | Economist | | F.D.I.C. | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a. CITY OR TOWN | | 13b. STREET ADDRESS | | | | | | | |
| 13a. STATE | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | | | | | | |
| Md. | | Montgomery | | Bethesda | | 5101 Ridgefield Road. | | | | | |
| 14 FATHER'S NAME | | 15 MOTHER'S MAIDEN NAME | | | | | | | | | |
| John C. Helm | | Amy Metcalf | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17 INFORMANT ADDRESS | | | | | | | |
| No | | 579-60-2094 | | Bethesda, Md.
Henry K. Armstrong, Lawyer. 5721 Ogden Rd. | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>N/A</i> | |
| 410-
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>MAY 17</i> 19 <i>79</i> , to <i>April 22</i> 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>APRIL 5</i> 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Oscar Mann M.D.</i> | | | | DEGREE | | | | 22c. DATE SIGNED
<i>4-22-80</i> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>OSCAR MANN M.D.</i> | | | | 22e. ADDRESS
<i>3301 New Mexico AV WASH DC</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN | | COUNTY | | STATE | |
| Burial | | 4/25/1980 | | Mt. Olivet Cemetery | | Hannibal | | Missouri | | | |
| 24 FUNERAL DIRECTOR
NAME <i>Joseph Gawler's Sons Inc.</i>
ADDRESS <i>5130 Wisc. Ave., N.W. Wash h., D.C.</i> | | | | 25a. DATE REC'D. BY REGISTRAR
<i>APR 23 1980</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Ritzy McBrady</i> | | | | | |

13221 A YB 1000000000

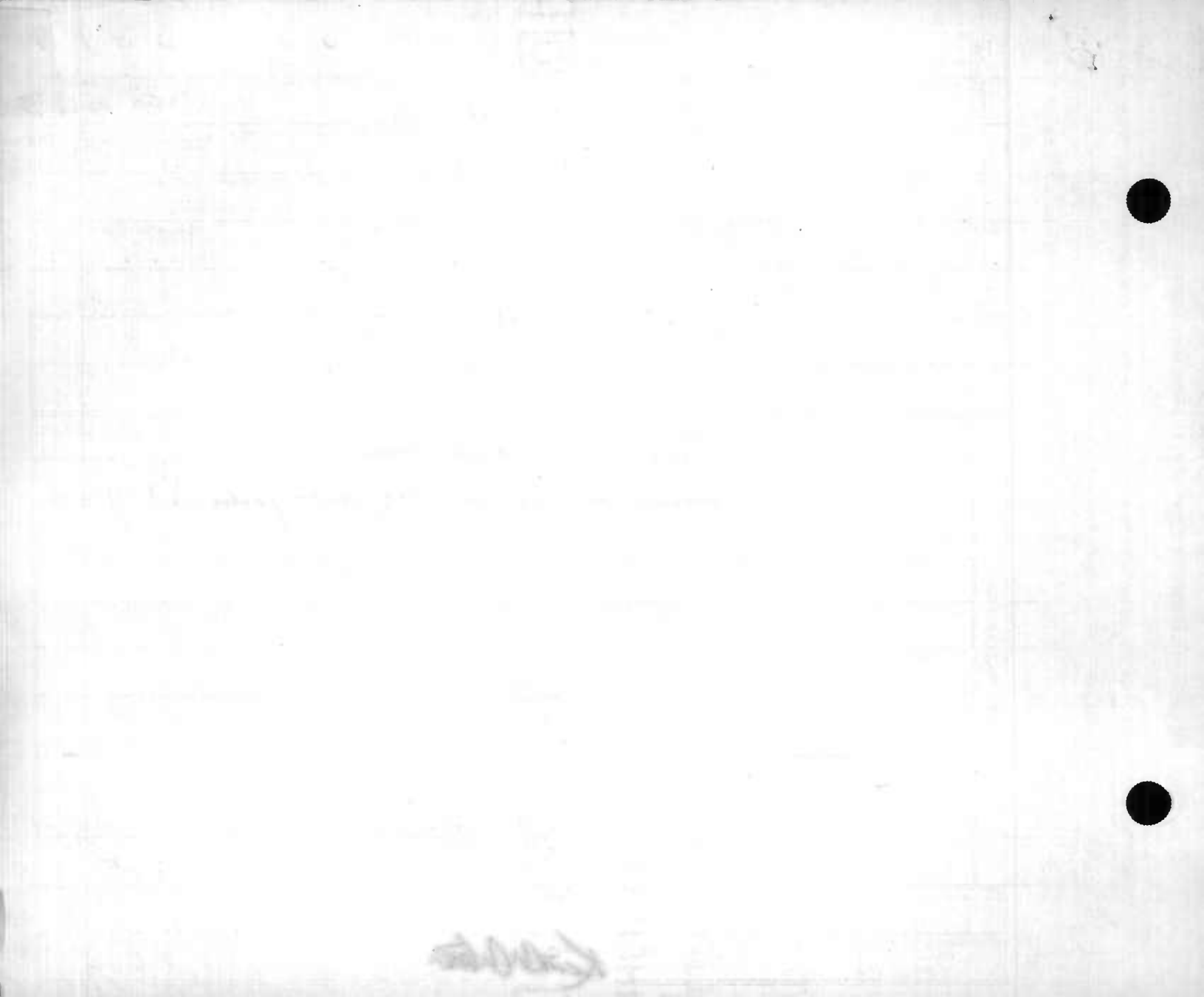
12/197A
T.M. 222222 8.28
T.M. 222222 8.28

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR
STATE
REGISTRAR | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8010679 | | | |
|--|--|---|--|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | | REG. NO. | | | |
| TAYLOR V HENDERSON | | | | 4-25-80 | | | | 12:28 AM | | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| Male | | White | | May 23 1919 | | 60 YRS | | MONTHS DAYS | | HOURS MIN | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Virginia | | USA | | Montgomery MD | | | | | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| Takoma Park | | Washington Adventist Hosp. | | | | Retired | | U.S. Govt. | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13a INSIDE CITY LIMITS? | | 13b STREET ADDRESS | | | | | |
| 13a STATE | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 2202 Van Buren Street, | | | | | |
| Maryland | | | | 13b CITY OR TOWN | | Hyattsville | | | | | |
| 14 FATHER'S NAME | | | | 15 MOTHER'S MAIDEN NAME | | | | | | | |
| James R. Henderson | | | | Jennette Stevens | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT (wife) ADDRESS | | | | | |
| yes | | | | WW | | Margaret E. Henderson-(same as 13e) | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Terminal pneumonia</u>
5728
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Acute & chronic Hepatitis fulminans</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>12 years</u> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (I) (the hospital) attended the deceased from <u>6-5-1956</u> <u>xx</u> to <u>4-24-</u> <u>1980</u> , that (I) (we) lost saw the deceased alive on <u>4-24-</u> <u>1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b SIGNATURE | | | | DEGREE | | | | 22c DATE SIGNED | | | |
| <u>Robert B. Irey</u> | | | | MD | | | | 4-25-1980 | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e ADDRESS | | | | | | | |
| ROBERT B. IREY | | | | 1161 New Hampshire Ave, Silver Spring, Md | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION
CITY OR TOWN COUNTY STATE | | | |
| Burial | | | | 4-28-80 | | Ft. Lincoln Cemetery | | Brentwood Pr. Georges Md | | | |
| 24 FUNERAL DIRECTOR | | | | 25a DATE REC'D. BY REGISTRAR | | | | 25b REGISTRAR'S SIGNATURE | | | |
| Warner E. Pumphrey, Inc.,
8434 Ga. Ave., S.S. Md. | | | | APR 30 1980 | | | | Patrick McCready | | | |



M.L.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

80

10680

FOR
1. STATE
REGISTRAR

REG. NO.

| | | | | |
|---|--|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
CLARENCE EUGENE HENSLEY | | 2a. DATE OF DEATH
MONTH DAY YEAR
APRIL 4, 1980 | | 2b. HOUR
9:15 p.m. |
| 3 SEX
MALE | 4 RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
JULY 28, 1926 | | 6. AGE (IN YEARS LAST BIRTHDAY)
53 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
North Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY | | MD. | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NATIONAL INSTITUTES OF HEALTH | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Machineist | 12b. KIND OF BUSINESS OR INDUSTRY
Steel Mfg. |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | |
| 13a. STATE
N.C. | 13b. COUNTY
Buncombe | 13c. CITY OR TOWN
WEAVERVILLE | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
P.O. BOX 494 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Robert Hensley | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Pearl Laws | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW II | 17. INFORMANT
ADDRESS
MRS. REVA HENSLEY - SAME ADDRESS | |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CIRCULATORY FAILURE/SHOCK</u>

2773
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <u>(AMYLOID) CARDIOMYOPATHY</u>
(c) <u>SYSTEMIC AMYLOIDOSIS</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | | |
|--|--|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |

| | | | |
|---|--|---|-----------------------------------|
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>MARCH 17</u> , 19 <u>80</u> , to <u>APRIL 4</u> , 19 <u>80</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>APRIL 4</u> , 19 <u>80</u> , and that in <input checked="" type="checkbox"/> (a) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. | | 22b. SIGNATURE
<u>Robert M. Lester</u>
DEGREE
MD
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED
<u>4/4/80</u> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>ROBERT M. LESTER</u> | | 22e. ADDRESS
NATIONAL INSTITUTES OF HEALTH
CLINICAL CENTER, BETHESDA, MD. 20205 | |

| | | | |
|--|---------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
Apr. 7, 1980 | 23c. NAME OF CEMETERY OR CREMATORY
Ashelawn Garden | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Weaverville, Buncombe, N.C. |
| 24. FUNERAL DIRECTOR
W. W. Chambers 8655 Georgia Ave
Silver Springs, Md. | | 25a. DATE REC'D. BY REGISTRAR
APR 9 1980 | |
| | | 25b. REGISTRAR'S SIGNATURE
<u>L. J. McQuinn</u> | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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North Carolina

Memphis

Robert

Henry

Robert

Yes

W 11

Copy to

APR 2 1980

APR 2 1980

APR 2 1980

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO.
8.0 10681 | |
|--|--|--|--|--|--|--|--|---|--|-----------------------------|--|
| 1. FOR STATE REGISTRAR | | 1 DECEASED NAME (TYPE OR PRINT)
John L. Hickey | | | | 2a DATE OF DEATH
April 29 80 | | 2b HOUR
6:15 A | | | |
| 3 SEX
male | | 4 RACE
white | | 5 DATE OF BIRTH
June 27 1900 | | 6 AGE (IN YEARS LAST BIRTHDAY)
79 YRS | | 7 UNDER 1 YEAR
MONTHS DAYS | | 8 UNDER 24 HRS
HOURS MIN | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Mass. | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | | | | | |
| 10 CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Civil service | | 12b KIND OF BUSINESS OR INDUSTRY
U.S. Government | | | |
| 13a STATE
Md. | | 13b COUNTY
Montgomery | | 13c CITY OR TOWN
Rockville | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS
261 Congressional Ln. Apt. T-7 | | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Michael J. Hickey | | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary nmi Sullivan | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b SOCIAL SECURITY NO
(IF YES, GIVE WAR OR DATES)
579-40-3876 | | 17 INFORMANT
George Hickey 111 Primrose St. Md. | | | | ADDRESS
Chevy Chase, Md. | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Ventricular Rhythm Disturbance</u>
4140
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Cornary Heart Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Generalized Atherosclerosis</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>minutes</u>
<u>years</u>
<u>years</u> | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):
<u>Old Stroke, Left Ventricular Failure.</u> | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK
NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22 I certify that (I) (this hospital) attended the deceased from <u>Oct 18</u> 19 <u>78</u> to <u>April 29</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>April 29</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Harris M. Kenner</u> | | | | DEGREE
<u>MD</u> | | | | 22c. DATE SIGNED
<u>4/29/80</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Harris M. Kenner | | | | 22e ADDRESS
10401 Old Georgetown Rd. Bethesda, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
5/1/80 | | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Alexandria Fairfax Va. | | | | | |
| 24 FUNERAL DIRECTOR
NAME
Tyson Wheeler Funeral Home, Inc.
1331 Rockville Pike Rockville, Md. 20852 | | | | 25a. DATE RECEIVED BY REGISTRAR
MAY 5 1980 | | 25b. SIGNATURE OF REGISTRAR
<u>[Signature]</u> | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | |
|---|--|--|--|--|--|---|----------|--|--|--|--|
| 1. FOR
STATE
REGISTRAR | | | 2. DATE OF DEATH MONTH DAY YEAR | | | | 2b. HOUR | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH
MONTH DAY YEAR | | |
| NELLIE ALBERTA HIMES | | | Female | | | White | | | Dec. 20 1924 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Maryland | | | U. S. A. | | | | | | Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION
(SUPERVISOR'S LAST WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Kensington | | | 4414 Woodfield Rd. Kensington, Md. | | | Conference Service | | | N.I.H. | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | |
| Maryland | | | Montgomery | | | Kensington | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | |
| William Henry Shaw | | | Julia V. Shoemaker | | | No | | | 216 14 5097 | | |
| 17. INFORMANT ADDRESS | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>ADENOCARCINOMA</u>
<u>1991</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK NOT AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>2-29</u> 19 <u>80</u> to <u>4-12</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>4-12</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Hubert J. Alpert</u> | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
<u>13 APR 80</u> | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>HUBERT J. ALPERT</u> | | | 22e. ADDRESS
<u>8630 FENTON ST.</u>
<u>SILVER SPRING, MD 20910</u> | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | |
| Burial | | | April 17, 1980 | | | Frederick Mem. Park | | | Frederick Frederick Md. | | |
| 25a. FUNERAL DIRECTOR
<u>Smith, Padeley, Keeney & Bassett</u> | | | 25b. DATE REC'D. BY REGISTRAR
<u>APR 17 1980</u> | | | 25c. REGISTRAR'S SIGNATURE
<u>Notary/Kelcey</u> | | | | | |
| 106 East Church Street, Frederick, Maryland | | | | | | | | | | | |

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PL 22

22

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 2. DATE OF DEATH | | | | | | 3. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2. DATE OF DEATH | | | | 3. HOUR | | 4. MIN. | |
| John Augustine Hipps | | Apr 21 80 | | | | 9:35 P | | M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | |
| MALE | | WHITE | | JULY 15, 1903 | | 76 YRS. | | MONTHS DAYS HOURS MIN. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 8. CITIZEN OF WHAT COUNTRY? | | 9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 10. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| PENNSYLVANIA | | U.S.A. | | | | Montgomery MD. | | | |
| 11. CITY OR TOWN OF DEATH | | 12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 13. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 14. KIND OF BUSINESS OR INDUSTRY | |
| Silver Spring | | Holy Cross Hospital | | | | PRINTER | | MERKLE PRESS | |
| 15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 16. CITY OR TOWN | | 17. INSIDE CITY LIMITS? | | 18. STREET ADDRESS | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| | | | | WASHINGTON, D.C. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1122 SHEPHERD ST., N.E. | |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) | | | | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) | | | | | |
| GEORGE HIPPS | | | | MARY SHARBAUGH | | | | | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT ADDRESS | | | |
| NO | | | | 578-09-9337 | | CATHERINE RITA HIPPS SAME AS 13 WIFE | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal failure</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 2030 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>Suprarenal cause</u> | | | | | | | | 5 days | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>Multiple Myeloma</u> | | | | | | | | 4 weeks | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>2 yrs.</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>11/15</u> 19 <u>77</u> to <u>4/21</u> 19 <u>80</u> that (I) (we) lost saw the deceased alive on <u>4/21</u> 19 <u>80</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 23. SIGNATURE | | DEGREE | | 24. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 25. DATE SIGNED | |
| Ira Tauber MD | | | | | | | | 4/21/80 | |
| 26. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 27. ADDRESS | | | | | |
| Ira Tauber MD | | | | 10301 Georgia Ave Silver Spring, MD | | | | | |
| 28. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 29. DATE | | 30. NAME OF CEMETERY OR CREMATORY | | 31. LOCATION CITY OR TOWN COUNTY STATE | | 32. DATE REC'D. BY REGISTRAR | |
| BURIAL | | 4/24/80 | | MT. OLIVET CEMETERY | | WASHINGTON, D.C. | | APR 25 1980 | |
| 33. FUNERAL DIRECTOR NAME FRANCIS J. COLLINGS 500 UNIV. BLVD. W. SILVER SPRING, MD. 20901 | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 8010684 | | | |
|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST | | | | 2b. HOUR | | | |
| CHAUDIA D. HOBBS | | | | APRIL 5 '80 11:10 P M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Female | | White | | 6 2 1892 | | 87 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Cooksville, Md. | | U.S.A. | | | | Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Gaithersburg | | Wilson Health Care Center | | Housewife | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13b. INSIDE CITY LIMITS? | | | |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN | | | | 13d. STREET ADDRESS | | | |
| Maryland Montgomery Gaithersburg | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 201 Russell Avenue | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | |
| Allen Bowie Carr | | | | Grace - Patrick | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT | | ADDRESS | |
| No | | - | | Records | | 201 Russell Ave., Gaithersburg, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4870 CONGESTIVE HEART FAILURE 3 days | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONITIS 3 WEEKS | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Influenza 1 month | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b): Shunt | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | OCT 75 4/5 80 | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 3/30 1980 to 4/5 1980, that (I) (we) last saw the deceased alive on 3/30 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | 22c. DATE SIGNED | |
| Thos G. Ward | | | | ATTENDING PHYSICIAN | | 4/6/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |
| Thos G. WARD 6116 ROBINWOOD, Bethesda, Md. 20834 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | April 9, '80 | | Good Shepherd Cem. | | Ellicott City, Howard, Md. | |
| 24. FUNERAL DIRECTOR | | 24b. ADDRESS | | 25a. DEATH BY REQUEST | | 25b. REGISTRAR'S SIGNATURE | |
| Gartner-Sandison | | 116 E. Diamond Ave. Gaithersburg, Md. | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8010685 | | | |
|--|--|--|--|--|--|--|--|----------------------------|--|------------------|-----|-------|----------|
| 1. FOR
STATE
REGISTRAR | | REG. NO. | | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2r. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR |
| LAURA | | E. | | HOGAN | | APRIL 27 | | 1980 | | 9:15 A.M. | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| female | | white | | December, 11, 1898 | | 87 YRS. | | MONTHS | | DAYS | | HOURS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Louisiana | | USA | | | | Montgomery | | | | | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12r. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12s. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Silver Spring | | University Nursing Home | | Accountant | | I.U.E. | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13r. STREET ADDRESS | | | | | |
| Maryland | | Montgomery | | Silver Spring | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 11447 Lockwood Drive # 103 | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| Charles | | D. Walter | | Hannah | | Hake | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | |
| No | | 579-42-3893 | | Robert L. Hogan | | same as 13 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): | | 4140 | | CARDIAC ARREST | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | hrs | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: | | DUE TO, OR AS A CONSEQUENCE OF | | Respiratory ARREST | | hrs | | | | | | | |
| | | DUE TO, OR AS A CONSEQUENCE OF | | Atherosclerotic Ht Disease with Congestive Heart Failure | | yrs | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): | | COPD, Diabetes mellitus, Pul Fibrosis | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | | | | | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | STREET | | CITY OR TOWN | | COUNTY | | STATE | | | |
| 22a. I certify that (1) this hospital attended the deceased from 4-25 1980 to 4-27 1980, that (1) I saw the deceased alive on 4-25 1980, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) we (did) (did not) view the body after death. | | 22b. SIGNATURE | | 22c. DATE SIGNED | | | | | | | | | |
| | | John L. Ford | | 4/28/80 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | | | |
| JOHN L. FORD, M.D. | | 344 UNIVERSITY BLVD, W. SILVER SPRING, MD. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | COUNTY | | STATE | | | |
| Burial | | Apr. 29, 1980 | | Fort Lincoln Cemetery | | Brentwood | | Pr. Geo. | | Md. | | | |
| 24. FUNERAL DIRECTOR NAME | | 24b. DATE REC'D. BY REGISTRAR | | 24c. REGISTRAR'S SIGNATURE | | | | | | | | | |
| Francis J. Collins | | APR 29 1980 | | Francis J. Collins | | | | | | | | | |
| 500 University Blvd., W. Silver Spring, Md. | | | | | | | | | | | | | |

500 University Blvd., N. Silver Spring, Md.

Francis J. Collins

Apr. 22, 1980 Fort Lincoln Cemetery, Bethesda, Md.

Pr. Geo. Md.

Burial

JOHN L. FORD, M.D.

314 UNIVERSITY BLVD., N.

SILVER SPRING, MD.

Attention: H-H Division with Consulting M.D.

COPY, Dr. John Ford, M.D., Silver Spring, Md.

Re: J. Ford, M.D., Silver Spring, Md.

RECEIVED

Robert L. Ford, 219-42-3893

same as 12

to

Charles T.

Robert

Henry

John

Marshall

Robertson, Silver Spring

11417 Lockwood Drive

103

Silver Spring

University Housing

Accommodations

I.H.E.

Louisiana

USA

X

Silver Spring

Genetic

infect

April 22, 1980

21

LAWYER

E.

HUMAN

APRIL 22

1980

115A

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 of 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|---|--|
| 1- FOR
STATE
REGISTRAR | | 80 10686
REG. NO. | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Russell A. Hogan | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
April 3, 1980 | | | 2b. HOUR
2:00p M | | |
| 3 SEX
Male | | 4 RACE
Cauc. | | 5. DATE OF BIRTH
MONTH DAY YEAR
June 27 1907 | | 6 AGE (IN YEARS LAST BIRTHDAY)
72 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | | | | |
| 10 CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Teller | | 12b. KIND OF BUSINESS OR INDUSTRY
Race Track | | |
| 13a. STATE
PA | | | | | 13b. COUNTY
✓ | | 13c. CITY OR TOWN
Philadelphia | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
John J. Hogan, Sr. | | | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Ward | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
164-14-0596 | | 17 INFORMANT
ADDRESS
Kevin Devine
77 Tennyson Dr. Shorts Hill, N.J. | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Bronchopneumonia, bilateral</u>
DUE TO OR AS A CONSEQUENCE OF (b) <u>Esophagitis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Pulmonary embolism, RLL</u>
(c) <u></u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>weeks</u>
<u>weeks</u>
<u>Days</u> | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/12</u> , 19 <u>80</u> , to <u>4/3</u> , 19 <u>80</u> , that (I) <u>was</u> last saw the deceased alive on <u>4/3</u> , 19 <u>80</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>was</u> (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>Alan N. Schulman</u> | | | | DEGREE
<u>MD</u> | | | 22c. DATE SIGNED
<u>4/3/80</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Alan Schulman, M.D. | | | | 22e. ADDRESS
19271 MONTGOMERY VILLAGE AVE
GAITHERSBURG, MD 20760 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
4-8-80 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Sepulchre Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Cheltenham Township PA | | | | |
| 24 FUNERAL DIRECTOR
NAME
Robert A. Pumphrey
Homes, P.A., Bethesda, Maryland | | | | 25a. DATE PROC. BY REGISTRAR
APR 9 1980 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | | |

BP

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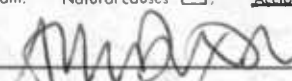

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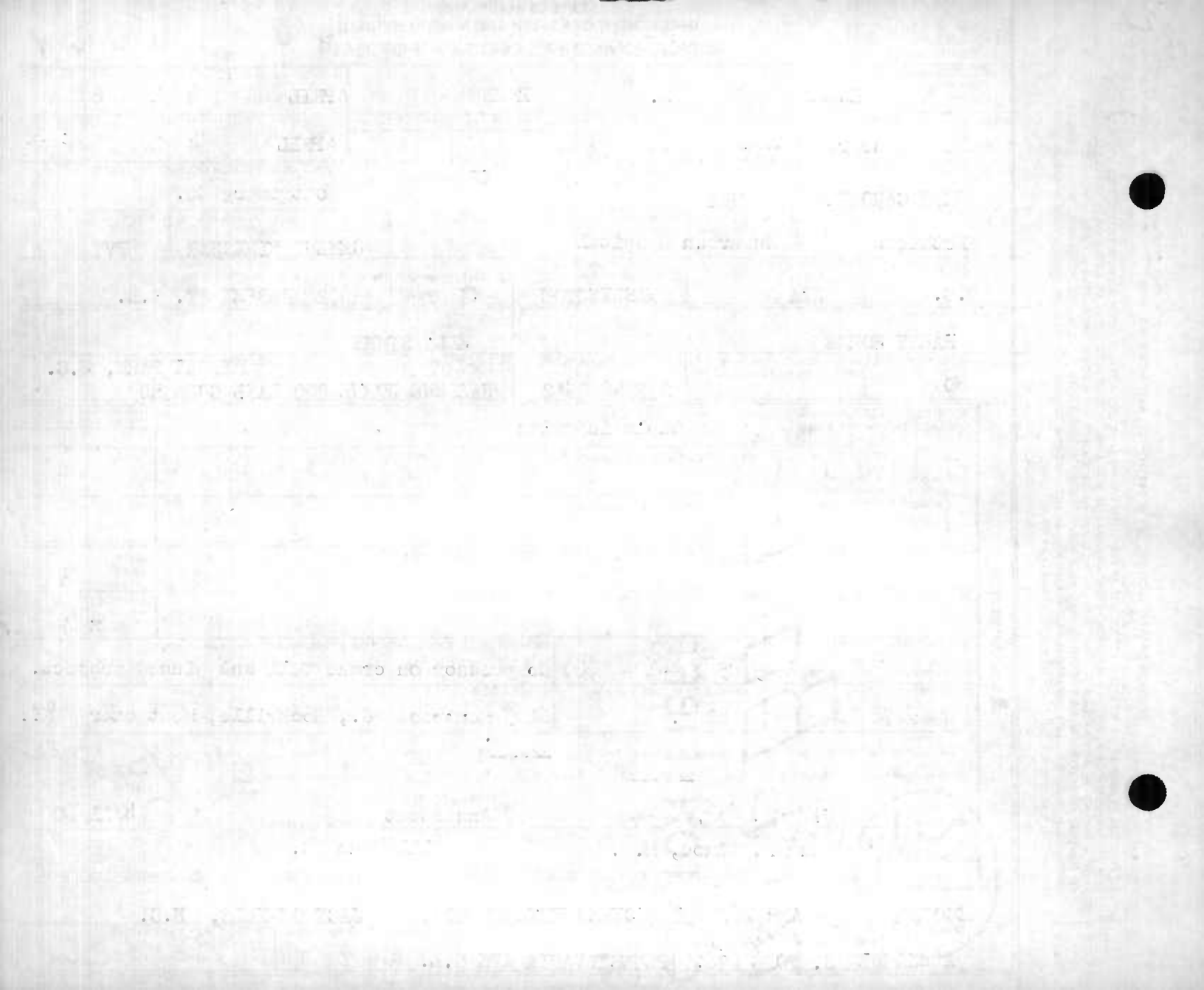
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

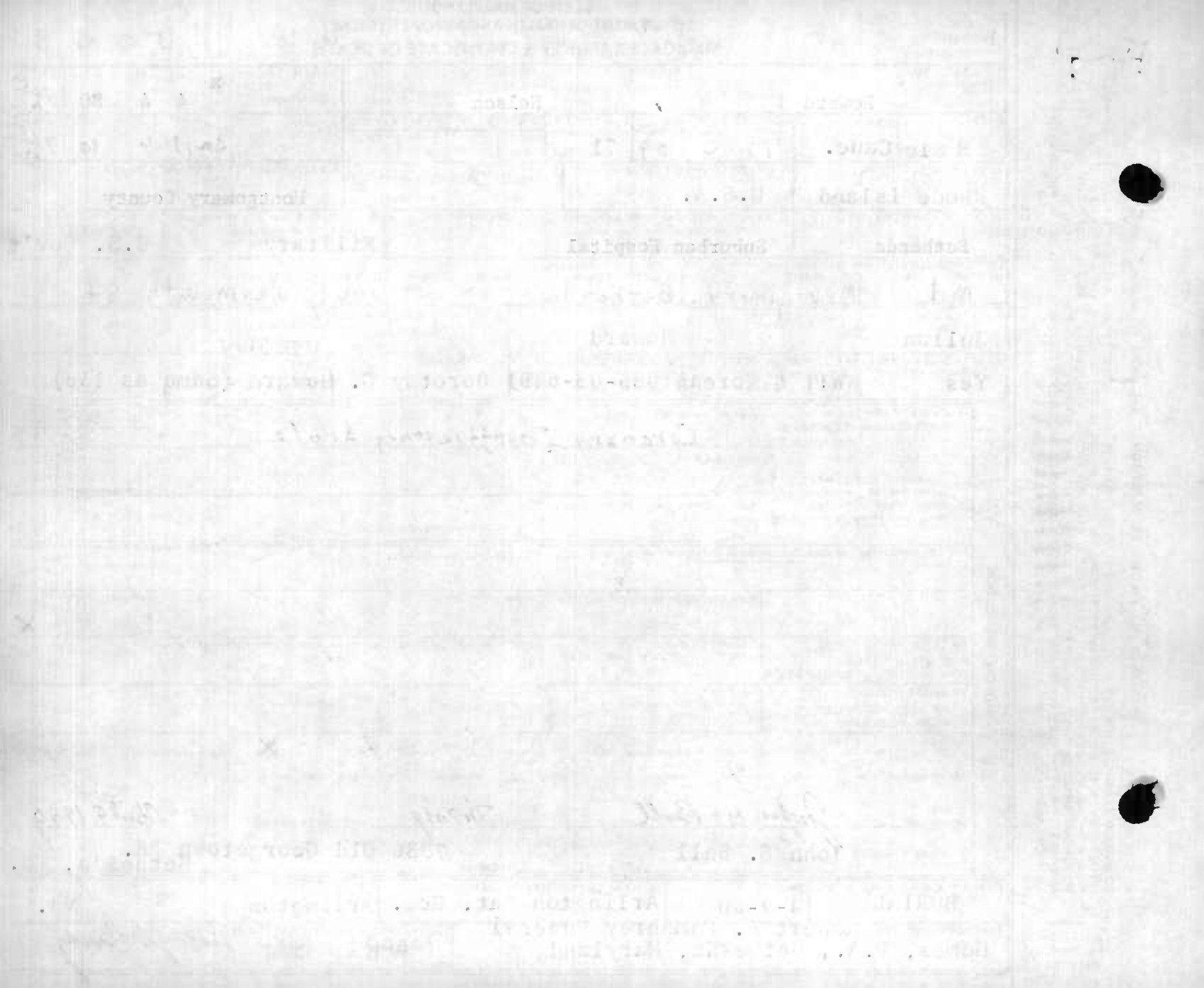
| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8010687 | | | | | |
|--|--|---|--|---|---|--|---|---|--|---|--|---|--|---------------------------------|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
HARRY L. HORNE | | | | | | | | 2a. DATE KNOWN OF ESTIMATED
APRIL 4 10 19 80 | | 2b. HOUR
M | | | |
| 3. SEX
male | | 4. RACE
negro | | 5. DATE OF BIRTH
MONTH DAY YEAR
MAY 10, 1933 | | 6. AGE (IN YEARS LAST BIRTHDAY)
46 YRS. | | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED
APRIL 4 10 19 80 | | 2d. HOUR
5:15 P M | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NORTH CAROLINA | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery Co. MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
CEMENT FINISHER | | | | 12b. KIND OF BUSINESS OR INDUSTRY
PVT | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | 13a. STATE
D.C. | | 13b. COUNTY
N?A | | 13c. CITY OR TOWN
WASHINGTON | |
| | | | | | | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
2802 JASPER ST. S.E. | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
HARRY HORNE | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ELLA SIMMS | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | | | 16b. SOCIAL SECURITY NO.
239 48 0512 | | | | | 17. INFORMANT ADDRESS
MIDWAY PARK, N.C.
HARLENE HORNE 200 LAKE COLE RD | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY: Multiple injuries
IMMEDIATE CAUSE (a):
9192
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c): | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | 21b. TIME OF INJURY
HOUR MIN. MONTH DAY YEAR
5:05 P.M. 4-10-19 80 | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
Compressor on crane fell and pinned subject. | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
bldg. | | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
6105 Montrose Rd., Rockville, Montgomery Md. | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
 | | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | | DATE SIGNED
4/11/80 | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Ann M. Dixon, M.D. | | | | | ADDRESS
111 Penn St. | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
REMOVAL | | | | | 23b. DATE
APR 15, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY
MCIVER FUNERAL HOME | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
JACKSONVILLE, N.C. | | | | | |
| 24. FUNERAL DIRECTOR
NAME
ALEXANDER S. POPE | | | | | 25a. DATE REC'D. BY REGISTRAR
2617 PENNSYLVANIA AVE S.E. APR 21 1980 | | | | | 25b. REGISTRAR'S SIGNATURE
 | | | | | |

MEDICAL CERTIFICATION



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8010688 | | | |
|---|--|---------------------------|--|---|--|---|--|---|--|---|--|---|--|
| 1- STATE REGISTRAR | | | | | | | | | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Nelson R. Howard | | | | | | | | | | ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
4 4 1980 | | 9:15 AM | |
| 3. SEX
Male | | 4. RACE
Cauc. | | 5. DATE OF BIRTH
MONTH DAY YEAR
Jan 9 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY)
71 YRS. | | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN | | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
April 4 1980 | | 7d. HOUR
9:15 AM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Rhode Island | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Military | | | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Gov't | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | |
| 13a. STATE
Md. | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
10670 Weymouth St. | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Julian Howard | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
UNKNOWN | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES/NO, OR UNKNOWN)
Yes | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WWII & Korean 085-03-6491 | | 17. INFORMANT ADDRESS
Dorothy G. Howard (Same as 13e) | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute.</u>
411-
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) _____
(c) _____
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
John G. Ball | | | | TITLE (SPECIFY)
M.D. Deputy | | | | DATE SIGNED
April 9, 1980 | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
John G. Ball | | | | ADDRESS
7936 Old Georgetown Rd. Bethesda, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | | 23b. DATE
4-9-80 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington Nat. Cem. | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arlington Va. | | | |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey
ADDRESS
Homes, P.A., Bethesda, Maryland | | | | | | 25a. DATE REC'D. BY REGISTRAR
APR 11 1980 | | 25b. REGISTRAR'S SIGNATURE
Anthony McCreedy | | | | | |



#18,22a, Film G543 5/23/80 kam

FOR
1- STATE
REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 10689

| | | | | | | | | | |
|---|---------|--|---|---|---|--|--------------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH
KNOWN
ESTIMATED | <input checked="" type="checkbox"/> MONTH | DAY | YEAR | 2b. HOUR |
| PATRICIA ANN HOZELA | | | | | 4-14- | 19 | 80 | | 5:20 a |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH
MONTH DAY YEAR | | 6. AGE (IN YEARS)
LAST BIRTHDAY | 7. IF UNDER 24 YRS.
MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR |
| female | White | 9 13 39 | | 40 YRS. | | | 4-14 19 80 | | a |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Washington, D.C. | | U.S.A. | | | | Montgomery County MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Gaithersburg | | 24421 Henson Dr. Road | | | | Housewife | | Own Home | |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | | | |
| Md. | | Montgomery | Gaithersburg | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 24421 Hanson Dr. Road | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | | |
| Martin Donohue | | | Rose DiGiacomo | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | |
| NO | | 217-36-8398 | | Walter A. Hozela | | 24421 Hanson Rd. Gaithersburg, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fatty Liver and pancreatitis</u>
5718
Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY? | |
| | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE <u>Margie D. Korell</u> | | | TITLE (SPECIFY)
Assistant | | | MEDICAL EXAMINER | | DATE SIGNED 4-14-80 | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | | ADDRESS | | | | | | |
| Margarita A. Korell, M.D. | | | 111 Penn Street | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| Burial | | 4/17/80 | | Geo. Washington Cem. | | Adelphi, Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME | | | ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Warner E. Pumphrey, Inc. | | | 8434 Ga. Ave. Sil. Spr., Md. | | | APR 21 1980 | | <u>Dorothy McCreedy</u> | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

10:3

10:3 10:3

10:3 10:3

10:3 10:3

10:3 10:3

10:3 10:3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 0 1 0 6 9 0 | | | |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) <u>Kathleen Marie Hubbard</u> | | | | 2a. DATE OF DEATH | | 2b. HOUR <u>11³⁵</u> P.M. | |
| 3. SEX <u>female</u> | | 4. RACE <u>white</u> | | 5. DATE OF BIRTH
MONTH <u>10</u> DAY <u>29</u> YEAR <u>1918</u> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<u>61</u> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>Maryland</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>Montgomery</u> MD. | |
| 10. CITY OR TOWN OF DEATH
<u>Bethesda</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>Suburban Hospital</u> | | 12a. USUAL OCCUPATION
(TYPE OF WORK OR MOST OF WORKING LIFE)
<u>retired</u> | | 12b. KIND OF BUSINESS OR INDUSTRY
<u>insurance</u> | |
| 13a. STATE
<u>Maryland</u> | | 13b. COUNTY
<u>Montgomery</u> | | 13c. CITY OR TOWN
<u>Rockville</u> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST <u>unknown</u> MIDDLE <u></u> LAST <u>Johnson</u> | | 15. MOTHER'S MAIDEN NAME
FIRST <u>Flörence</u> MIDDLE <u></u> LAST <u>Gray</u> | | 16. STREET ADDRESS
<u>6111 Montrose Rd. #627</u> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<u>no</u> | | 16b. SOCIAL SECURITY NO.
<u>403 18 5307</u> | | 17. INFORMANT
NAME <u>Edward W. Hubbard III</u> ADDRESS <u>317 Silversmith Ct. Ashland, Virginia 23005</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>CARDIOGENIC SHOCK</u>
<u>4254</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>ISCHEMIC CARDIOMYOPATHY</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) <u></u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>6 days</u>
<u>4 months</u> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u></u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/23/80</u> to <u>4/23/80</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did (did not) view the body after death.) | | | | | | | |
| 22b. SIGNATURE
<u>Roger Stevenson, Jr MD</u> | | | | DEGREE
<u>MD</u> | | 22c. DATE SIGNED
<u>4/24/80</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>ROGER STEVENSON, JR MD</u> | | | | 22e. ADDRESS
<u>1125 ROCKVILLE PIKE ROCKVILLE, MD</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>Cremation</u> | | 23b. DATE
<u>4/25/80</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Metropolitan Creamery</u> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>Alexandria, Virginia</u> | |
| 24. FUNERAL DIRECTOR
NAME <u>Tyson Wheeler Funeral Home, Inc.</u> ADDRESS <u>1331 Rockville Pike Rockville, Maryland</u> | | | | 25a. DATE REC'D. BY REGISTRAR
<u>APR 28 1980</u> | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

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0.22

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|---------|---|-------------------|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| Christian Gabriel Hurtado | | 4 29 1980 | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | 7. IF UNDER 1 YR. | 8. IF UNDER 24 HRS. |
| Male | White | 1/15/80 | 3 | 14 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| Maryland | | U.S.A. | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| Rockville | | Shady Grove Adventist Hospital | | NONE | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. INSIDE CITY LIMITS? | | 13b. STREET ADDRESS | |
| NONE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 705 Crabb Avenue | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16. SOCIAL SECURITY NO. | |
| Sergio F. Hurtado | | Mirtha Rey | | NONE | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | NONE | | Sergio F. Hurtado, same as #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | |
| Thomas D. Smith | | M.D. Deputy Chief | | 4/30/80 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | |
| Thomas D. Smith, M.D. | | 111 Penn St. | | Balto., MD. | |
| 23a. BURIAL (S) CREMATION, REMOVAL | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 5/2/80 | | Gate of Heaven Cemetery | |
| 23d. LOCATION CITY OR TOWN | | 23e. COUNTY | | 23f. STATE | |
| Silver Spring | | Maryland | | | |
| 24. FUNERAL DIRECTOR NAME | | 24b. ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | |
| Robert A. Pumphrey | | Funeral Homes, P.A. | | MAY 8 1980 | |
| 7557 Wisconsin Avenue, Bethesda, MD | | | | | |

MEDICAL CERTIFICATION

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

1/15/60

U.S.A.

Maryland

302 Crab Avenue

Rochville

Montgomery

Maryland

Ray

Wirtia

Hurtado

E.

Serito

Serito E. Hurtado, same as #13

ONE

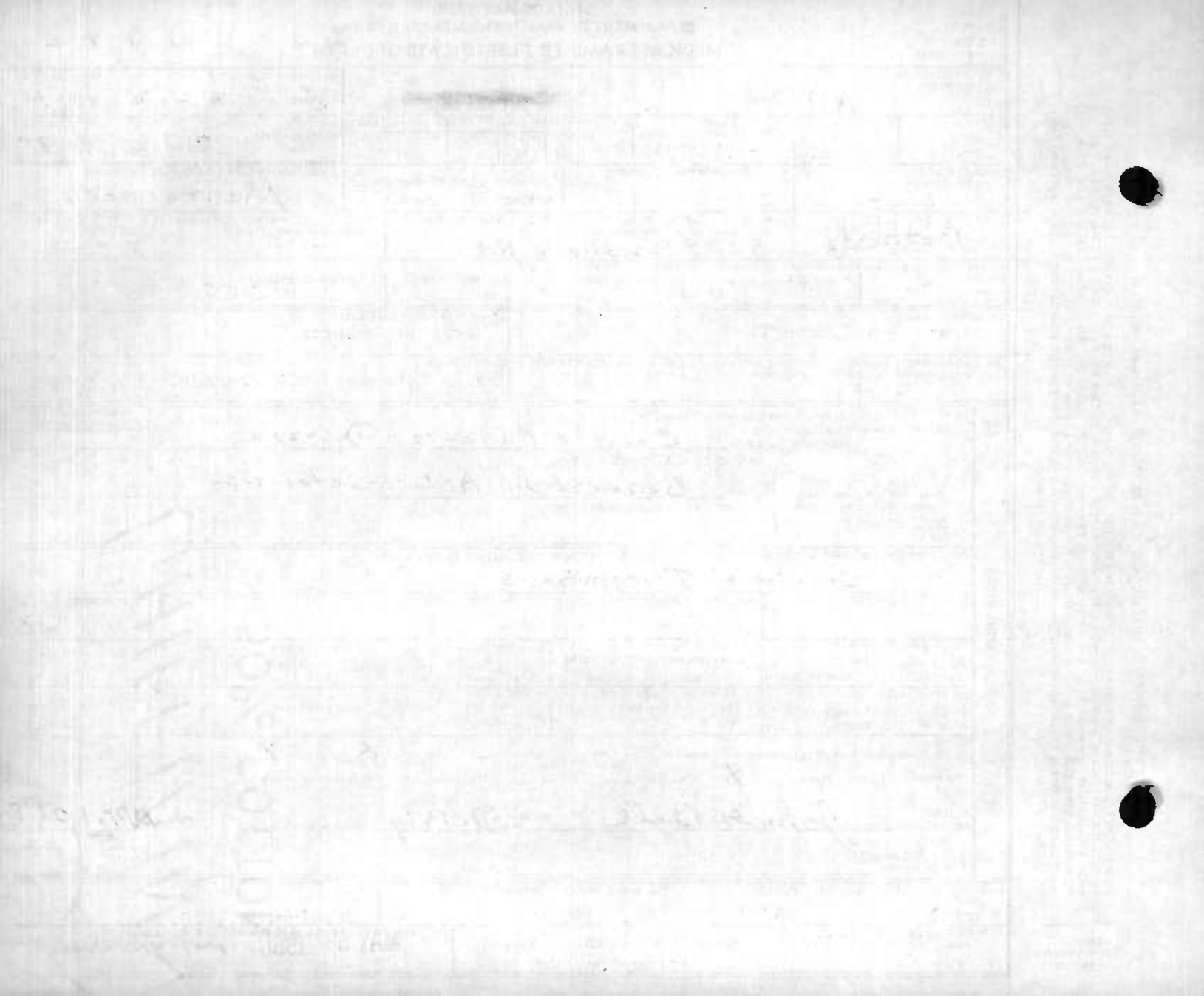
NO

Robert J. Murphy Funeral Home, Inc.
7557 Wisconsin Avenue, Bethesda, MD
Date of Death: January 15, 1960
Silver Spring, Maryland

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

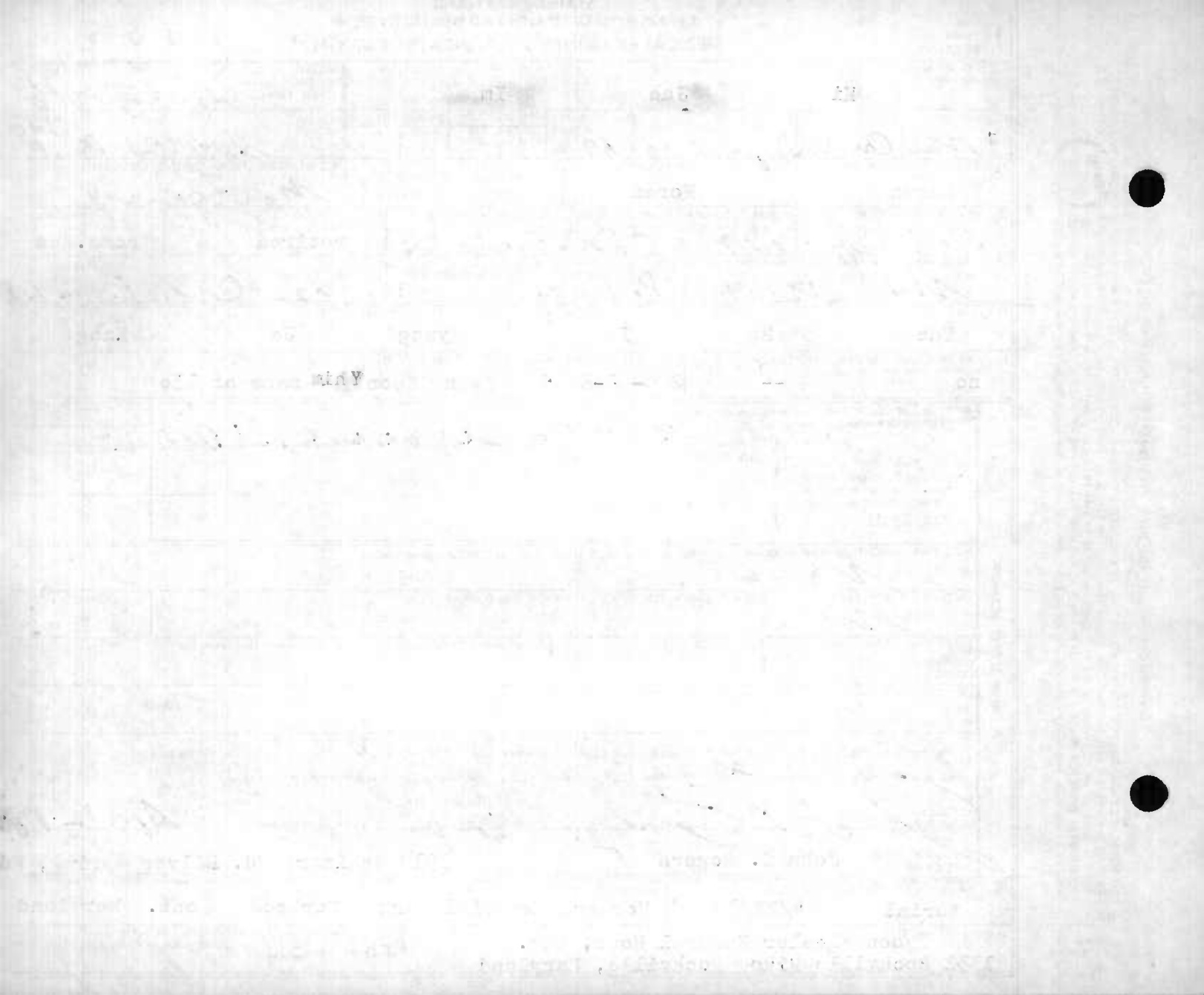
MEDICAL CERTIFICATION

| FOR STATE REGISTRAR | | | | | | | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 100692 | | | | | | | | | | | | | | | | | | | |
|---|--|------------------|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Anna O. Hutchins | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR
4-26 1980 | | | | | | | | | | 2b. HOUR
A | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX
female | | 4. RACE
Cauc. | | 5. DATE OF BIRTH MONTH DAY YEAR
Mar. 14 1890 | | 6. AGE (IN YEARS LAST BIRTHDAY)
90 YRS. | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR
April 26 1980 | | | | | | | | | | 2d. HOUR
9 A | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Wash. D.C. | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery | | | | | | | | | | MD. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
5008 Scarsdale Rd. | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
retired | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY
US Gov't | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. STATE
Md. | | | | | | | | | | 13b. COUNTY
Montgomery | | | | | | | | | | 13c. CITY OR TOWN
Sumner | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 13e. STREET ADDRESS
5008 Scarsdale Rd. | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Jeremiah O'Connell | | | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Margaret Roberts | | | | | | | | | | MD. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)
No | | | | | | | | | | 16b. SOCIAL SECURITY NO.
579-60-3458 | | | | | | | | | | 17. INFORMANT ADDRESS
Doris Lohmeyer/5008 Scarsdale Rd. Sumner | | | | | | | | | | MD. | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiovascular Disease.
4292
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) Generalized Arterio Sclerosis.
(c)
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
Cerebral Thrombosis | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | TITLE (SPECIFY)
Deputy | | | | | | | | | | DATE SIGNED
April 26 '80 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
John S. Ball | | | | | | | | | | M.D. | | | | | | | | | | MEDICAL EXAMINER | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
John S. Ball | | | | | | | | | | ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
5/2/80 | | | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Olivet | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Washington, D.C. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME
Murphy Funeral Home | | | | | | | | | | ADDRESS
4510 Wilson Blvd. Arlington, Va. | | | | | | | | | | 25a. DATE DECEASED BY REGISTRAR
MAY 5 1980 | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE
Morty McBrady | | | | | | | | | | | | | | | | | | | |



DHMH - 17
(VR A15 ME (5))
30M 7/73

| FOR STATE REGISTRAR | | | | | | | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 10693 | | | | | | | | | | | | | | | | | | | |
|--|--|---------------------|--|--|--|--|--|---|--|---|--|---|--|--|--|--|--|--|--|--|--|------------------------------|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Ki Jae Im | | | | | | | | | | 2a. DATE KNOWN OF DEATH MONTH DAY YEAR
April 12, 1980 | | | | | | | | | | 2b. HOUR OF DEATH
2:00 PM | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX
Male | | 4. RACE
Oriental | | 5. DATE OF BIRTH MONTH DAY YEAR
Sept 15, 1969 | | 6. AGE (IN YEARS LAST BIRTHDAY)
69 YRS. | | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 8. IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR
April 12, 1980 | | | | | | | | | | 2d. HOUR OF DEATH
2:00 PM | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Korea | | | | 7b. CITIZEN OF WHAT COUNTRY?
Korea | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
12922 Christie Field Rd | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
retired | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY
Trans. Bus | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. STATE
MD | | | | | | | | | | 13b. COUNTY
Mont | | | | | | | | | | 13c. CITY OR TOWN
Silver Spring | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 13e. STREET ADDRESS
12922 Christie Field Rd | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Tae Ho Im | | | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Hyung Ja Kang | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)
no | | | | | | | | | | 16b. SOCIAL SECURITY NO.
220-92-3835 | | | | | | | | | | 17. INFORMANT ADDRESS
Kyung Soon Yhim same as 13e | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
4291 IMMEDIATE CAUSE (a) Acute Myocardial Infarction
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b)
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
None | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
None | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | | | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
[Signature] | | | | | | | | | | TITLE (SPECIFY)
M.D. | | | | | | | | | | DATE SIGNED
April 15, 1980 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
John S. Rogers | | | | | | | | | | ADDRESS
1919 Seminary Rd. Silver Spring, Md | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | | | | | | | 23b. DATE
4/23/80 | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY
Norbeck Memorial Park | | | | | | | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Norbeck Mont. Maryland | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME
Tyson Wheeler Funeral Home, Inc.
1331 Rockville Pike Rockville, Maryland | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR
APR 28 1980 | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

DHMH - 16 50M 1/76
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 1 0 6 9 4

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Samantha MARIE Jackson | | | 2a. DATE OF DEATH MONTH DAY YEAR
April 7, 80 | | | 2b. HOUR
9:25 P.M. | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
10 13 79 | | 6. AGE (IN YEARS LAST BIRTHDAY)
6 mo. | | 7. UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Unfv. of Md. Hesp. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Silver Springs | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Great Oaks Center | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
N.A. | | 12b. KIND OF BUSINESS OR INDUSTRY
N.A. | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE md 13b. COUNTY Prince Geo. 13c. CITY OR TOWN Laurel | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
8822 Hunting Lane | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Edward Benjamin Jackson | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Carol Ann McKay | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
214-94-0954 | | 17. INFORMANT ADDRESS
Edward B. Jackson Same as #13 (Father) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio-respiratory failure
DUE TO, OR AS A CONSEQUENCE OF:
(b) Diffuse central nervous system damage.
DUE TO, OR AS A CONSEQUENCE OF:
(c) Meconium aspiration | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
30 min.
Since birth
at birth. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from March 7, 19 80 to April 7, 19 80 , that (I) (we) last saw the deceased alive on April 7, 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Winston E. Cochran M.D. | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
4/8/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Winston E. Cochran, M.D. | | | | | | 22e. ADDRESS
12001 Cherry Hill Rd Silver Spring, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
4/10/80 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Brentwood P.G. Md. | | | |
| 24. FUNERAL DIRECTOR
Francis Gasch's Sons Funeral Home, P.A. | | | | | | 25a. DATE REC'D. BY REGISTRAR
APR 10 1980 | | 25b. REGISTRAR'S SIGNATURE
Ruby Holley | |
| Hyattsville, Maryland | | | | | | | | | |

MEDICAL CERTIFICATION

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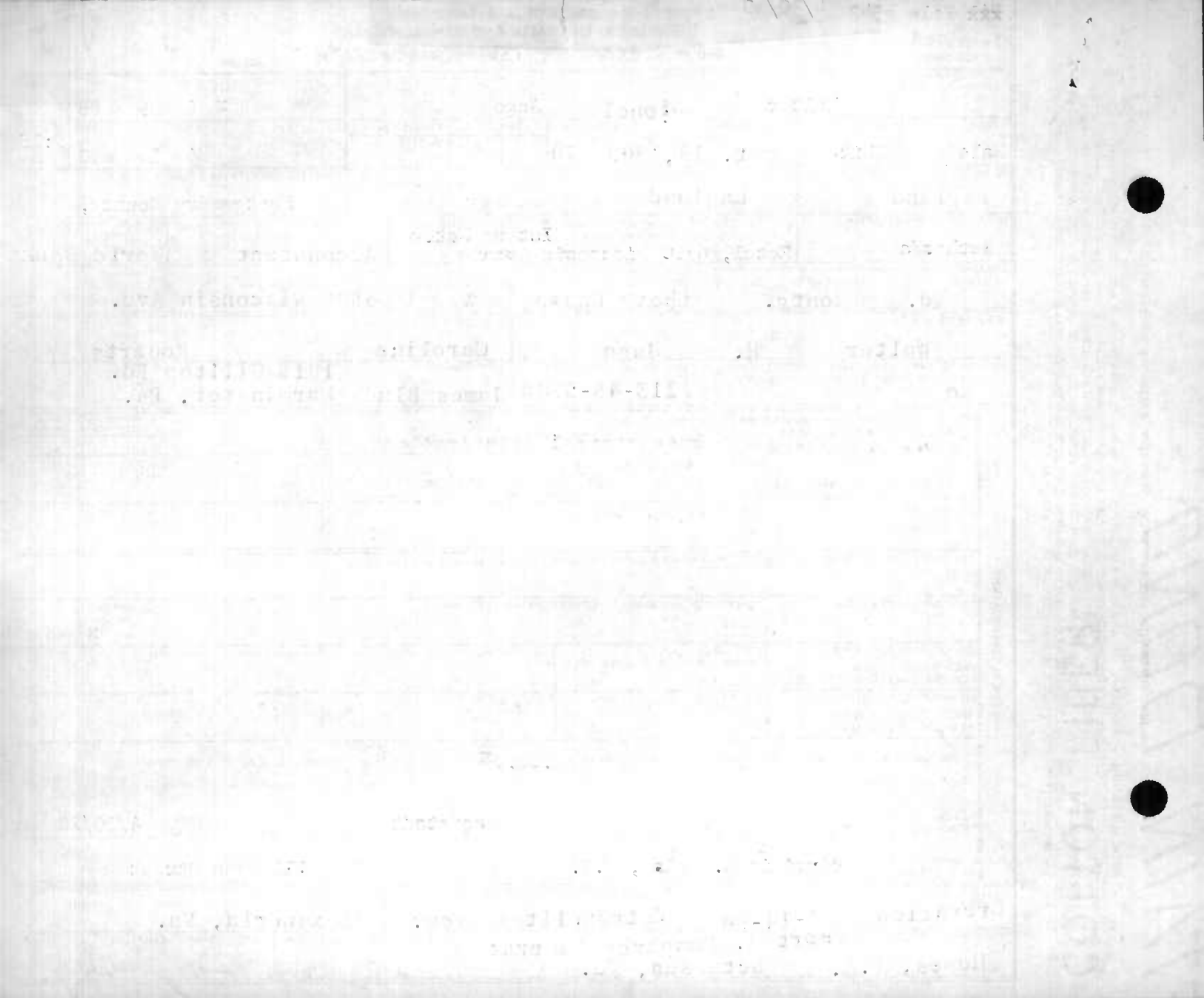
RECEIVED
JAN 10 1980

TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]
[The body of the letter contains several paragraphs of extremely faint, illegible text.]

APR 10 1980
[illegible signature]
[illegible text]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| 1. DECEASED NAME
(TYPE OR PRINT) | | | | | | | | | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | | | |
|--|--|---------|--|---|--------------------------|-------------------|--|--|--|--|--|---|--|---|--|
| Walter Lionel Jago | | | | | | | | | | ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR | | 4 9 19 80 | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | 7. IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | 7d. HOUR | | | |
| Male | | White | | Sept. 19, 1909 | | 70 | | MONTHS DAYS HOURS MIN | | 4 10 19 80 | | 9:15 A M | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| England | | | | England | | | | | | | | Montgomery County, MD | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Bethesda | | | | Intown Motor Hotel, 6800 Wisconsin Avenue | | | | Accountant | | | | World Bank | | | |
| 13a. STATE | | | | | | | | | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13d. STREET ADDRESS | |
| Md. | | | | | | | | | | Montg. | | Chevy Chase | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 6800 Wisconsin Ave. | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | |
| Walter H. Jago | | | | | Caroline Roberts | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT | | | | | |
| No | | | | | 213-48-5808 | | | | | James Blue 1018 Adelphi Rd. Warminster, Pa. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Acute ethanol intoxication</u> | | | | | | | | | | | | | | | |
| 3050 | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? | | | |
| | | | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| | | | | P.M. 19 | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | | | | | |
| Virginia L. Dolan MD | | | | Assistant | | | | 4/10/80 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | | | |
| Virginia L. Dolan, M.D. | | | | 111 Penn Street | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Cremation | | | | 4-14-80 | | | | Metropolitan Crem. | | | | Alexandria, Va. | | | |
| 24. FUNERAL DIRECTOR NAME | | | | ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Robert A. Pumphrey | | | | Homes, P.A. Bethesda, Md. | | | | APR 16 1980 | | | | Duffy McCreedy | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|---|-----------------------------|--|--|---|--|---|--|---|------------------------------|------------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE KNOWN
OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR
10 ^{PM} |
| FRANK JAMES JANCAR, Jr.
<i>Frank Jancar</i> | | | | | 4-28 1980 | | | | | |
| 3. SEX
<i>Male</i> | 4. RACE
<i>White</i> | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>9 3 14</i> | | 6. AGE (IN YEARS
LAST BIRTHDAY)
<i>65</i> YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. | 7c. DATE
PRONOUNCED
DEAD
<i>April 28, 1980</i> | | 2d. HOUR
10 ^{PM} | |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)
<i>Ohio</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery</i> MD. | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Bethesda</i> | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Suburban Hospital</i> | | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)
<i>Tech Photo.</i> | | 12b. KIND OF BUSINESS
OR INDUSTRY
<i>U.S. Gov't.</i> | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13a. STREET ADDRESS | | | | | |
| 13a. STATE
<i>Md.</i> | 13b. COUNTY
<i>Mont.</i> | 13c. CITY OR TOWN
<i>Bethesda</i> | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
<i>6510 --79th Place</i> | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Frank J. Jancar</i> | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Agnes Intihar</i> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
<i>Yes WW11</i> | | 16b. SOCIAL SECURITY NO.
<i>276-03-3790</i> | | 17. INFORMANT
ADDRESS
<i>Mary B. Jancar, Wife. Same as item 13.</i> | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Coronary Insufficiency Acute</i>
<i>411-</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET | | CITY OR TOWN | | COUNTY | STATE | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | |
| ACTUAL
SIGNATURE
<i>John S. Ball</i> | | TITLE (SPECIFY)
<i>Deputy</i> | | MEDICAL EXAMINER | | | | DATE
SIGNED <i>April 28, 1980</i> | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
<i>John G. Ball, M.D.</i> | | ADDRESS <i>7936 Old Georgetown Rd., Beth., Md.</i> | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>5/1/1980</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Gate of Heaven Cemetery</i> | | 23d. LOCATION
CITY OR TOWN
<i>Alilver Spring, Maryland.</i> | | COUNTY | STATE | |
| 24. FUNERAL DIRECTOR <i>Joseph Gawler's Sons Inc.</i>
NAME ADDRESS
<i>5130 Wisc. Ave., N.W. Wash., D. C.</i> | | | | | 25a. DATE REC'D. BY REGISTRAR
<i>MAY 5 1980</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Henry McCreedy</i> | | | |



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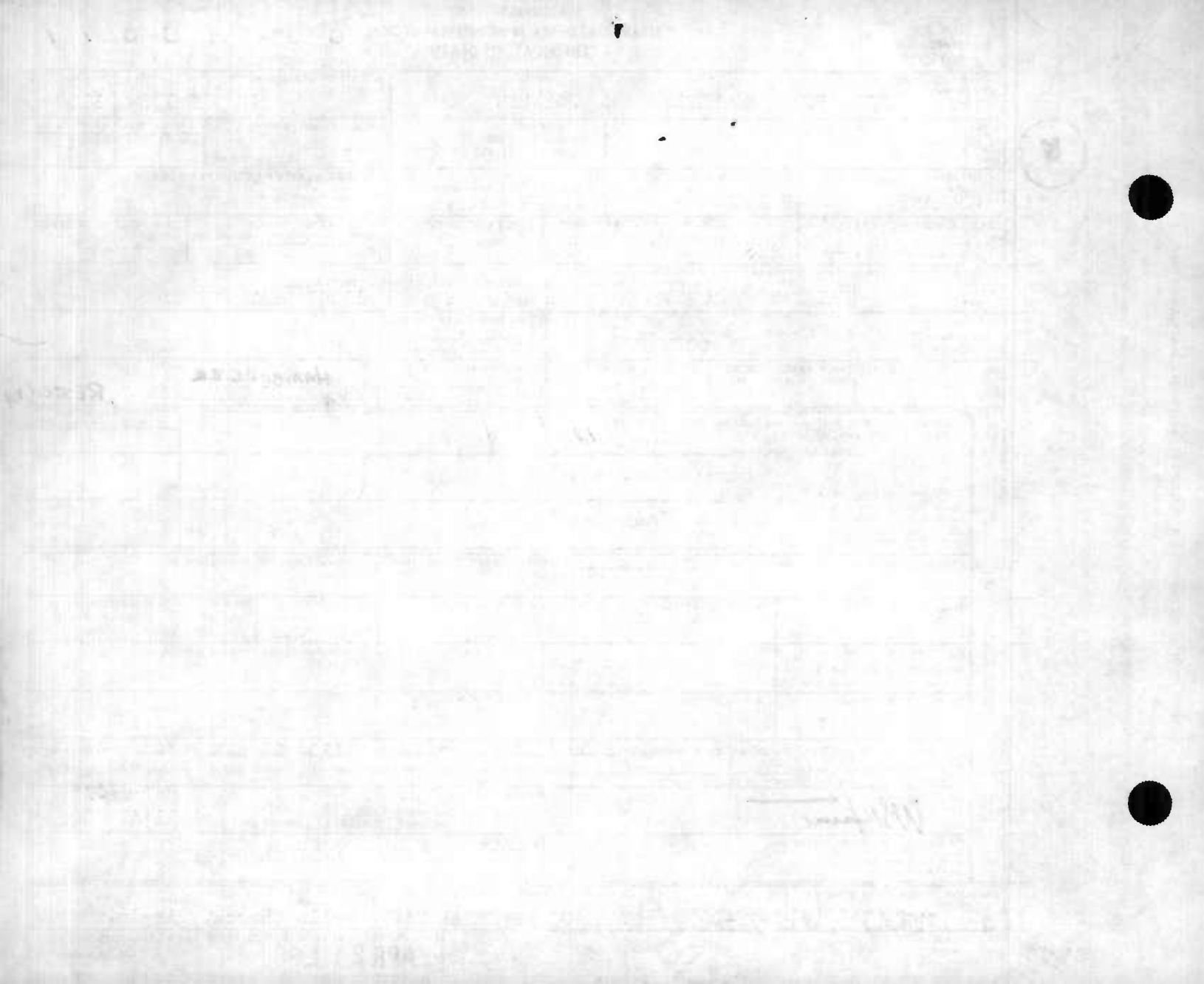
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with-in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|---|--|--------------------------------------|---|-----------------|---|--|
| 1. FOR STATE REGISTRAR | | | REG. NO. 8010697 | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) ELIZABETH CATHERINE JATTEAU | | | 2a. DATE OF DEATH MONTH DAY YEAR APR 11 1980 | | | | 2b. HOUR 1134 M | | |
| 3. SEX FEMALE | | 4. RACE CAU | | 5. DATE OF BIRTH MONTH DAY YEAR NOV 06 1906 | | 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GERMANY | | 7b. CITIZEN OF WHAT COUNTRY? FRANCE | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | | | |
| 10. CITY OR TOWN OF DEATH BETHESDA MD. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NATIONAL NAVAL MEDICAL CENTER | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY OWN HOME | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE VA. 13c. COUNTY FAIRFAX 13d. CITY OR TOWN RESTON | | | 14. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 15. STREET ADDRESS 11207 LEATHERWOOD | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST CHARLES SCHMITT | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH HAUCK | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO 093/24/3535 | | 17. INFORMANT ADDRESS DAUGHTER PAULETTE HAMBURGER 11207 LEATHERWOOD, RESTON, VA | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) METASTATIC CA 1991
DUE TO, OR AS A CONSEQUENCE OF (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2400 31 MAR 1980 to 1134 11 APR 1980, that (I) (we) last saw the deceased alive on 11 APR 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE [Signature] DEGREE | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 11 APR 80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. HUNT | | | | 22e. ADDRESS NATIONAL NAVAL MEDICAL CENTER | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 4-16-80 | | 23c. NAME OF CEMETERY OR CREMATORY NATIONAL MEMORIAL PARK | | 23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church, Virginia | | | |
| 24. FUNERAL DIRECTOR NAME Money and King ADDRESS Lawyers Rd. Vienna, Virginia | | | | 25a. DATE REC'D. BY REGISTRAR APR 21 1980 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|--|--|---|--|---|--|
| 1. FOR
STATE
REGISTRAR | | 8 0 1 0 6 9 8 | | REG. NO. | | | | | |
| 1 DECEASED NAME
(TYPE OR PRINT) ANNA Elizabeth Johnson | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
April 23 1980 | | 2b. HOUR
M
10:10 PM | | | |
| 3 SEX
Female | | 4 RACE
WHITE | | 5 DATE OF BIRTH
MONTH DAY YEAR
MARCH 18, 1887 | | 6 AGE (IN YEARS LAST BIRTHDAY)
93 YRS. | | 7 UNDER 1 YEAR
MONTHS DAYS
10 10 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PENNSYLVANIA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10 CITY OR TOWN OF DEATH
Wheaton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University Nursing Home | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SEAMSTRESS | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MARYLAND | | | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
SILVER SPRING | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
THOMAS LEV | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARY CANNON | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO
(IF YES, GIVE WAR OR DATES)
137-14-0821 | | 17 INFORMANT
ADDRESS
HELENE M. KOHLMAN SAME AS 13 DAUGHTER | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) 3979 Congestive Heart Failure.
DUE TO, OR AS A CONSEQUENCE OF
(b) Rheumatic Valvular Heart Disease.
DUE TO, OR AS A CONSEQUENCE OF
(c) Arteriosclerotic Cardiovascular Disease. | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
4 days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
Arteriosclerotic Cardiovascular Disease. | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 19 65 , to 4-23 19 80 , that (I) (we) last saw the deceased alive on 4-19 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Morton Altshuler M.D. | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
4-23-80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Morton Altshuler, M.D. | | | | 22e. ADDRESS
1299-LANCASTER DR. Silver Spring, Md. 20902 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
4/29/80 | | 23c. NAME OF CEMETERY OR CREMATORY
HOLY CROSS CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
YEADON DELAWARE PA. | | | |
| 24 FUNERAL DIRECTOR
NAME
FRANCIS J. COLLINS | | ADDRESS
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | 25 DATE REC'D. BY REGISTRAR
APR 25 1980 | | 25b. REGISTRAR'S SIGNATURE
Henry McCreedy | | | |

| | | | |
|--------------|-------------|-----------------|---------------------|
| NO | 197-14-0001 | WILET M. KWHMAN | SALE AS IF IMPROVED |
| THOMAS | LEV | MALE | COMMON |
| HARVARD | MONROVIA | SILVER STRIP XX | 1185 OAK LEAF DRIVE |
| PENNSYLVANIA | U.S.A. | | SEATTLE |
| | WHITE | MARCH 12, 1997 | |

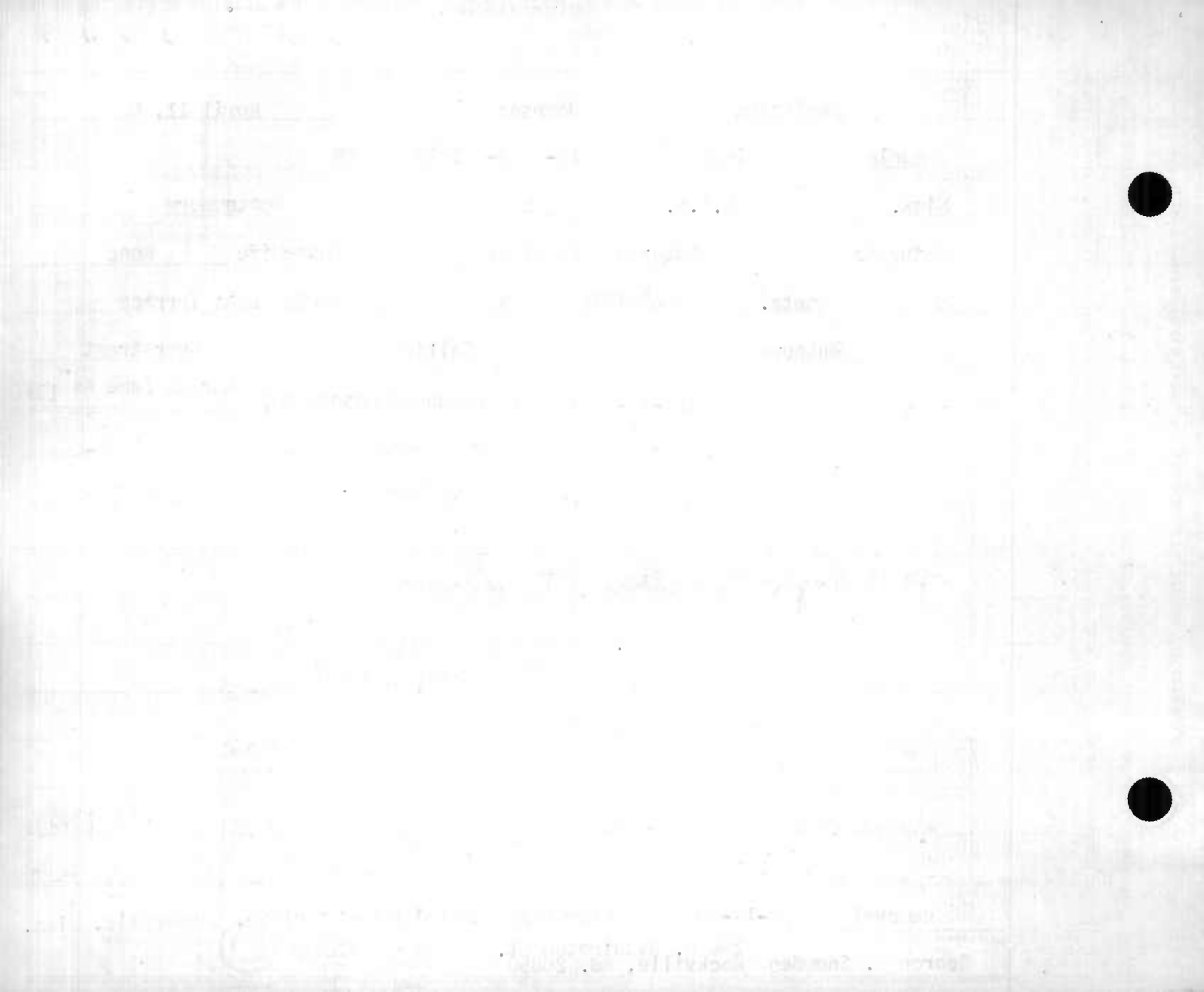
500 UNIT 2ND, N. SILVER STRIP, MD 20901
 FRANCIS J. COLLINS
 HOLY CROSS CEMETERY
 VERDON DELAWARE PA.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8010699 | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|---|--|--|--------------------------|--|-------|---------------------|-----|--|------|--|----------|--|
| 1. FOR STATE REGISTRAR | | | REG. NO. | | | | | | | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | | | MIDDLE | | | LAST | | | 2a. DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| Christine | | | Johnson | | | | | | | | | April | | 11 | | 80 | | M | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | 7. IF UNDER 1 YEAR | | | 8. IF UNDER 24 HRS | | | | | | |
| Female | | | Black | | | 12- 8- 1910 | | | 69 | | | YRS | | | MONTHS | | | DAYS | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | | |
| Miss. | | | U.S.A. | | | | | | Montgomery | | | MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | |
| Bethesda | | | Suburban Hospital | | | Housewife | | | None | | | | | | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET ADDRESS | | | | | | |
| Md | | | Montg. | | | Rockville | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 14828 | | | Lake Terrace | | | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | |
| Unknown | | | Callie | | | Overstreet | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO | | | 17. INFORMANT | | | ADDRESS | | | | | | | | | | | | |
| No | | | 428-10-2410 | | | Mr. Johnny Johnson (Son) | | | Address Same As 13#E | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Cerebral thrombosis | | | | | | | | | | 1 wk | | | | | | | | | | | |
| 2030 } DUE TO, OR AS A CONSEQUENCE OF (b) Multiple myeloma | | | | | | | | | | 5 yrs | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | | | |
| Pathologic fracture of femur | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | | | | | |
| | | | HOUR A.M. MONTH DAY YEAR | | | Turning in bed | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION | | | | | | | | | | | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | terwood n h. | | | CITY OR TOWN | | | COUNTY | | | | | | | | | | | | |
| | | | | | | STREET | | | STATE | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/80, 19, to 4/11/80, 19, that (I) (we) lost saw the deceased alive on 4/11/80, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED | | | | | | | | | | | | |
| Jeremy B. Cooke MD | | | | | | | | | 4/11/80 | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | | | | | | | | | | | | | | | | |
| Jeremy B. Cooke | | | 10400 Corner Ave Kensington | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION | | | | | | | | | | | | |
| Removal | | | 4-14-80 | | | Enterprize Funeral Home | | | Meridan, Lauderdale, Miss. | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | 24b. ADDRESS | | | 25. DATE REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | |
| George R. Snowden | | | 246 N. Washington St. Rockville, Md. 20850 | | | APR 17 1980 | | | | | | | | | | | | | | | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|--|-------------------------|---|---|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FRANK LEE JOHNSON Jr. | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
4 20 1980 | | | 2b. HOUR
3:15 PM | | |
| 3. SEX
male | 4. RACE
black | 5. DATE OF BIRTH
MONTH DAY YEAR
July 23 1941 | 6. AGE (IN YEARS)
LAST BIRTHDAY
38 YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
4 20 1980 | 2d. HOUR
P | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | |
| 10. CITY OR TOWN OF DEATH
Silver Springs | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
8750 Georgia Ave. Apt 1201 | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Taxi Driver | | 12b. KIND OF BUSINESS OR INDUSTRY
Taxi's | |
| 13a. STATE
Maryland | | 13b. CITY OR TOWN
Montgomery | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS
8750 Georgia Avenue, | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Frank L. Johnson | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Roxie Rucker | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
227-50-4349 | | 17. INFORMANT (brother)
Bruce A. Johnson- | | | ADDRESS
(same as 13e) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Narcotism
3049
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE
Margie to R. Korell | | TITLE (SPECIFY)
Assistant | | | | | DATE SIGNED
4-21-80 | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Margarita A. Korell, M.D. | | ADDRESS
111 Penn Street | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremated | | 23b. DATE
4-22-80 | | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Alexandria Fairfax Va. | | |
| 24. NAME OF REGISTRAR
Warner E. Pumphrey, Inc. | | | | 8434 Ga. Ave.
Sil. Spr. Md. | | 25a. DATE DEC'D BY REGISTRAR
APR 28 1980 | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

2000 2001 2002 2003 2004

01/12/2010 10:00 AM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 0 1 0 7 0 1 | | | |
|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) AMY E. JONES | | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| | | | | MONTH DAY YEAR | | 10.20 P.M. | |
| 3. SEX Female | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| | | | | MONTH DAY YEAR | | 78 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Canada | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH Rockville, Md. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Potomac Valley Nursing Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Assembler | | 12b. KIND OF BUSINESS OR INDUSTRY Powder Co. | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Md. 13c. COUNTY Montg. | | 13d. CITY OR TOWN Rockville | | 13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13f. STREET ADDRESS 632 Azalea Drive | |
| 14. FATHER'S NAME (TYPE OR PRINT) William Renshaw | | 15. MOTHER'S MAIDEN NAME (TYPE OR PRINT) Mary Holbrook | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 077-10-7981A | | 17. INFORMANT ADDRESS Edward J. Cochrane, Jr. Same as 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of the lung
1629
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11 19 79 , to 11-11 19 80 , that (I) (we) lost saw the deceased alive on 4-9 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE D C Bucy | | | | 22c. DATE SIGNED 4-11-80 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) D C Bucy | | | | 22e. ADDRESS 809 Veins Mill Rd Rockville | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Apr. 15, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY Wiltwyck Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Kingston, New York | |
| 24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Homes, P.A. Bethesda, Md. | | | | 25a. DATE REC'D. BY REGISTRAR APR 16 1980 | | 25b. REGISTRAR'S SIGNATURE Patricia McCreedy | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

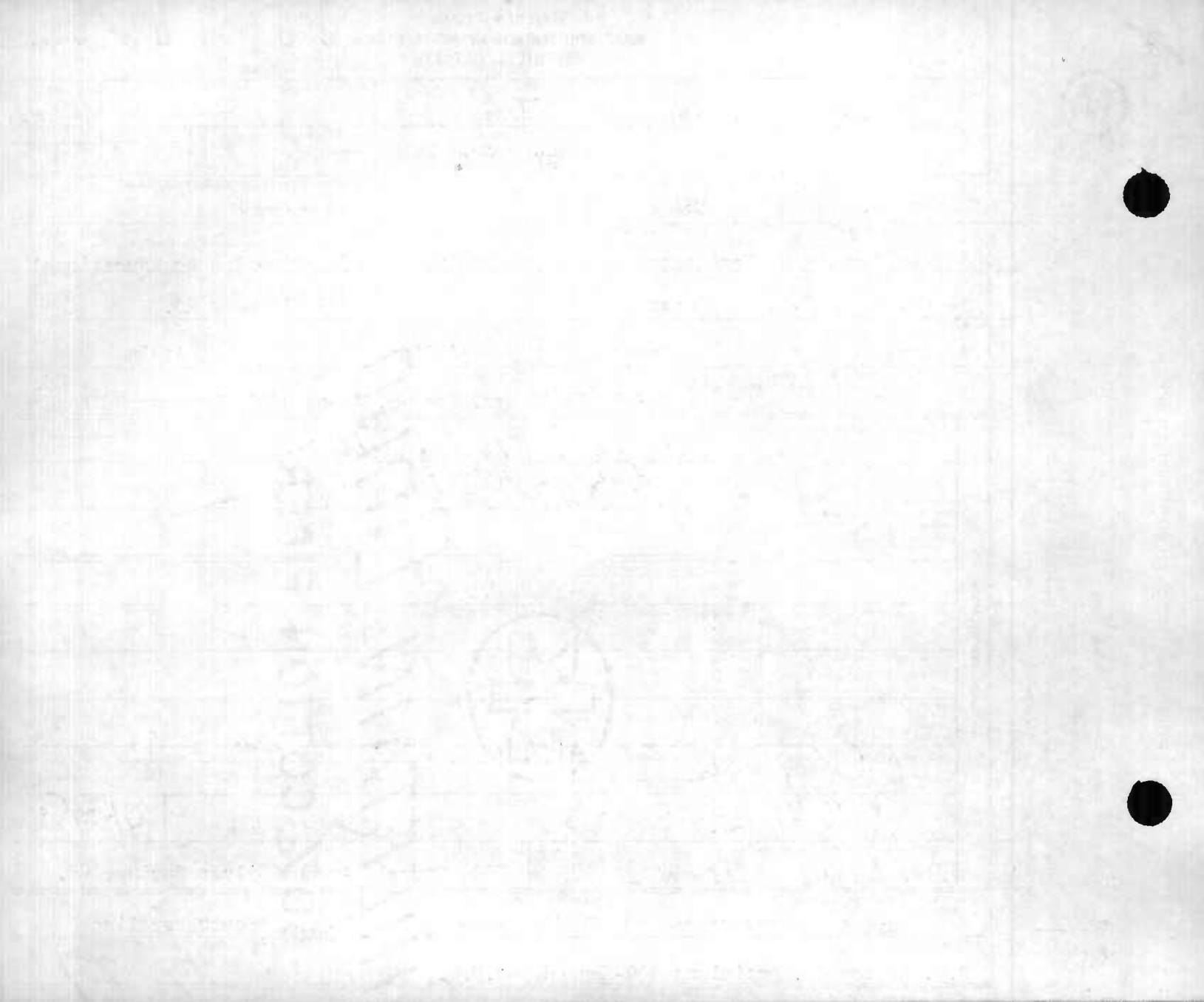
8 0

1 0 7 0 2

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|---|---|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) George Washington Jones | | | 2a. DATE OF DEATH MONTH DAY YEAR
4-26-80 | | | 2b. HOUR
6:08 AM | | | |
| 3. SEX
Male | | 4. RACE
Negro | | 5. DATE OF BIRTH
MONTH DAY YEAR
5/ 15/ 24 | | 6. AGE (IN YEARS LAST BIRTHDAY)
55 | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Camden, S.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park, Md | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington adventist hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Educational Spec | | 12b. KIND OF BUSINESS OR INDUSTRY
Educational | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | 13b. COUNTY
P.G. | | 13c. CITY OR TOWN
Lanham | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
4405 Kinmount Rd. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Adam Jones | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Willie Mae Atkin | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | | 16b. SOCIAL SECURITY NO.
247 32 7604 | | 17. INFORMANT ADDRESS
Mrs. Rose M. Jones 4405 Kinmount Rd Lanham Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ruptured aorta
DUE TO, OR AS A CONSEQUENCE OF (b) hypertension
DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
4 PM 4/26/80 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
fall | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
home | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
7600 Carroll Avenue Silver Spring, Md. | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 4/26/80 to 4/26/80 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
DR. LEWIS DENNIS | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
4/26/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DR. LEWIS DENNIS | | | 22e. ADDRESS
7600 Carroll Avenue Silver Spring, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
5/3/1980 | | 23c. NAME OF CEMETERY OR CREMATORY
Family Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Camden South Carolina | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
R.N. Horton Co. Morticians 600-Kennedy St. N.W. | | | | | 25a. DATE REC'D BY REGISTRAR
MAY 1 1980 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | |
|--|---|--|--|--|-----------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Ronald P. JONES, Jr. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
4-6-80 | | 2b. HOUR
6:03 PM | |
| 3 SEX
M | 4 RACE
Negro | 5. DATE OF BIRTH
MONTH DAY YEAR
4-6-80 | | 6 AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS
2 42 | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
MD. | 7b. CITIZEN OF WHAT COUNTRY?
U. S. | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | |
| 10 CITY OR TOWN OF DEATH
SIL. SPRING | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
HOLY CROSS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
None | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD. 13b. COUNTY Mont. 13c. CITY OR TOWN Sil. Sprg. | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
RONALD P. JONES | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
SHEILA Y JONES | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
None | | 17 INFORMANT
ADDRESS
Ronald P. Jones, Sr. SAA | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Scarce Dysphagia
7651 DUE TO, OR AS A CONSEQUENCE OF (b) 23 wk gestation
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | |
| 19a. DATE OF OPERATION
N.A. | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
N.A. | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
4 6 1980 | | | | |
| 21c. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21d. PLACE OF INJURY
(FARMHOUSE, STREET, FACTORY, OFFICE, FARM, ETC.)
N.A. | | | | |
| 21e. LOCATION
STREET FIRST CITY OR TOWN COUNTY STATE
N.A. | | 21f. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
N.A. | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 4/6/80 to 4/6/80 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
EUGENE SUSSMAN, MD | | DEGREE | | 22c. DATE SIGNED
4/6/80 | | |
| 22d. PHYSICIAN'S NAME (IF FORMAL) | | 22e. ADDRESS
2401 Blue Ridge Avenue
Wheaton, Maryland 20902 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
4/9/80 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cem. | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Sil. Sprg. Mont. Md. | | 24. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
APR 14 1980 Henry McCready | | | | |

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P. J.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5. IF THE DECEASED WAS A MEMBER OF THE U.S. ARMY, NAVY, AIR FORCE, MARINE CORPS, OR COAST GUARD, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

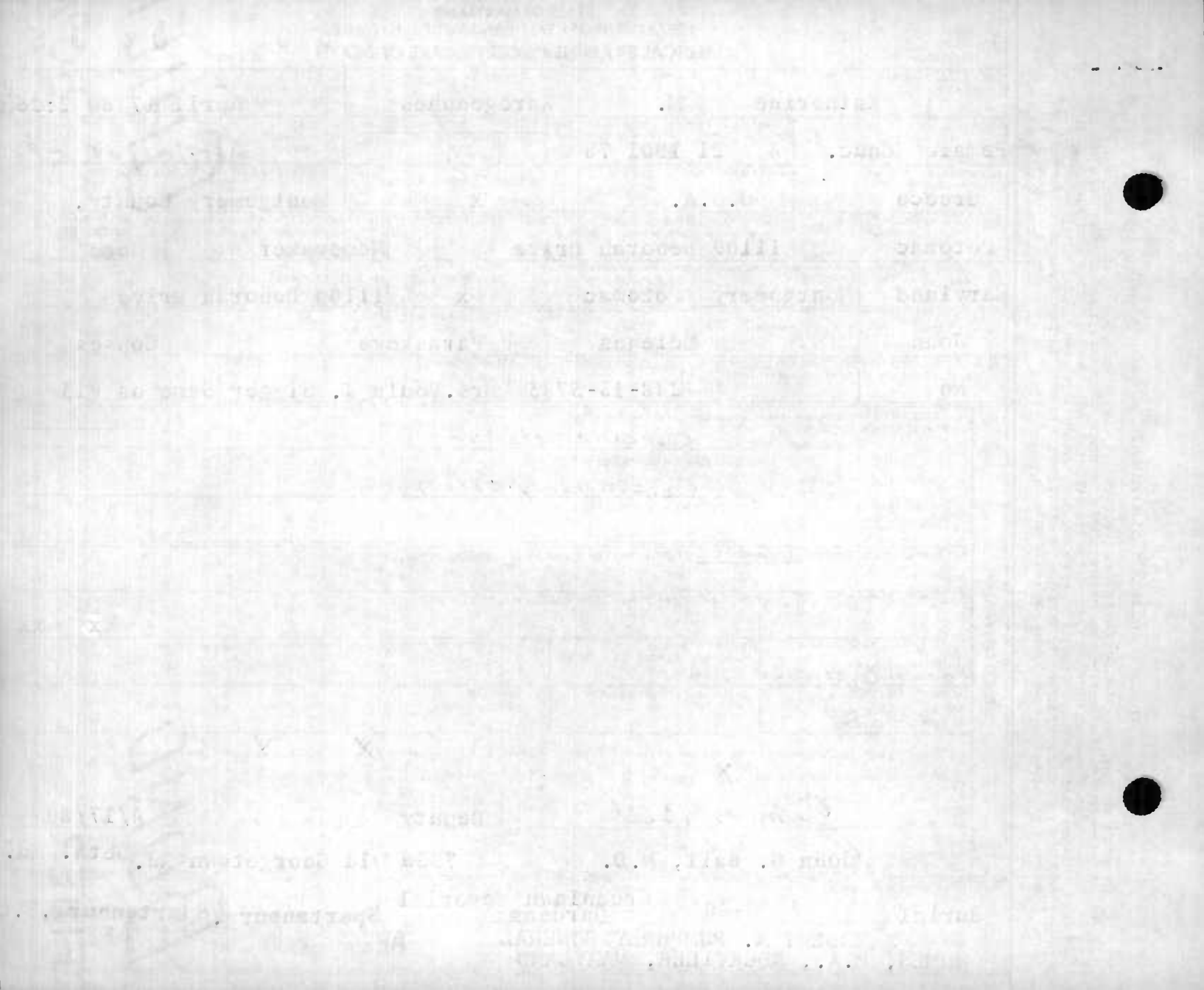
REG. NO.

| | | | |
|---|-----------|---|---|
| 1. FOR STATE REGISTRAR | | 3010704 | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | 2a. DATE KNOWN OF DEATH | |
| FIRST MIDDLE LAST
Mary L. JOYCE | | ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
APR 17 1980 | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) |
| Female | Cauc. | Jul. 22 1884 | 95 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | |
| Lithuania | | USA | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | |
| Bethesda | | National Naval Medical Center | |
| 12a. USUAL OCCUPATION | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Housewife | | Home | |
| 13a. STATE | | 13b. CITY OR TOWN | |
| Maryland | | Montgomery | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | |
| FIRST MIDDLE LAST
Alexander Lukashevich | | FIRST MIDDLE LAST
Ludmilla Elbovich | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | |
| (YES, NO, OR UNKNOWN) No | | (IF YES, GIVE WAR OR DATES) 220 70 9164 | |
| 17. INFORMANT | | ADDRESS | |
| Mrs. Annette J. Lauer | | See item 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Cardio Vascular Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | |
| 20a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21d. LOCATION CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | TITLE (SPECIFY) Deputy MEDICAL EXAMINER | |
| ACTUAL SIGNATURE <u>John G. Ball</u> | | DATE SIGNED Apr. 18 1980 | |
| EXAMINER'S NAME (TYPE OR PRINT) JOHN G. BALL, M.D. | | ADDRESS 7936 Old Georgetown Rd. Bethesda, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE |
| Burial | 4-21-80 | Mt. Olivet Cemetery | Washington, D. C. |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | 25a. DATE RECEIVED BY REGISTRAR | |
| Robt. A. Pumphrey Funeral Home, Bethesda, Md. | | APR 21 1980 | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8010705 | | | |
|---|--|----------------------|--|---|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) Katherine M. Karegeannes | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR April 17 1980 | | | |
| 3. SEX Female | | 4. RACE Cauc. | | 5. DATE OF BIRTH
MONTH DAY YEAR 4 21 1901 | | 6. AGE (IN YEARS)
LAST BIRTHDAY 78 YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN | | 2b. DATE PRONOUNCED DEAD April 17 1980 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Greece | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD. | | | |
| 10. CITY OR TOWN OF DEATH Potomac | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11109 Deborah Drive | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY Home | | | |
| 13a. STATE Maryland | | | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Potomac | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 11109 Deborah Drive | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST John Melehes | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST Paraskeve Copses | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 248-15-3783 | | 17. INFORMANT ADDRESS Mrs. Voula K. Singer Same as #13 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinomatosis -
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. 1539
(b) Carcinoma of colon
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY?
YES NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL SIGNATURE John G. Ball | | | | TITLE (SPECIFY) Deputy | | | | DATE SIGNED 4/17/80 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) John G. Ball, M.D. | | | | ADDRESS 7936 Old Georgetown Rd, Beth. Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (S-E-C-F-Y) Burial | | | | 23b. DATE 4-20-80 | | 23c. NAME OF CEMETERY OR CREMATORY Greenlawn Memorial Gardens | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE Spartanburg, Spartanburg, S.C. | | | |
| 24. FUNERAL DIRECTOR
NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A., ROCKVILLE, MARYLAND | | | | 25a. DATE REC'D. BY REGISTRAR APR 24 1980 | | | | 25b. REGISTRAR'S SIGNATURE Jeffrey A. Cready | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

DHMH-16 25M
(VRA 15, 4) 1/79

Cleared with medical examiner

MEDICAL CERTIFICATION

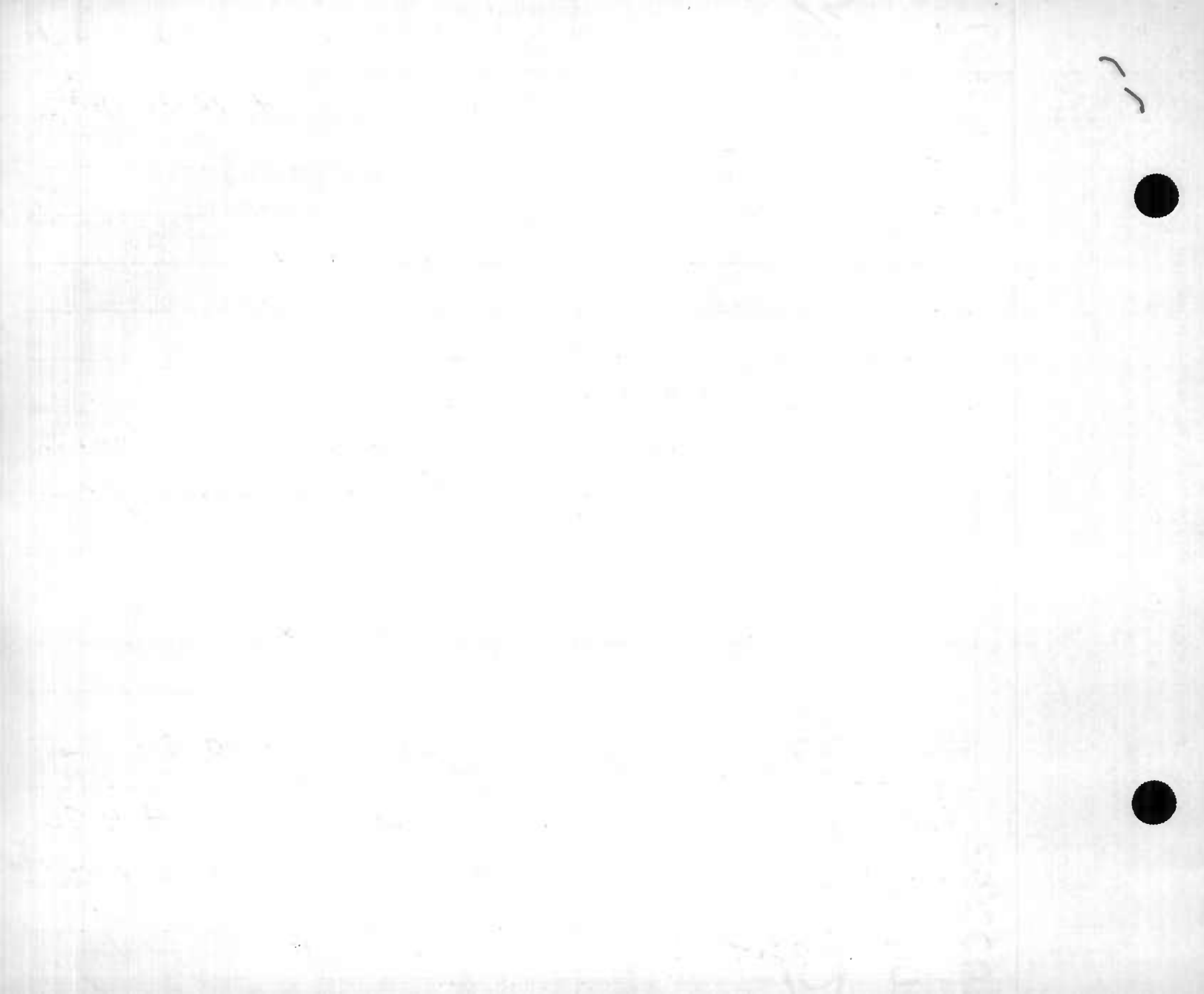
| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|---|---|--|--|--|---|-----------------------------------|--|--|
| 1. FOR
STATE
REGISTRAR | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | |
| LAURA FAY KARSH | | APRIL 20, 1980 | | | | 5:15 A.M. | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| FEMALE | CAUCASIAN | JUNE 20, 1927 | | 52 YRS. | | MONTHS DAYS | | HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| NEW JERSEY | USA | | | MONTGOMERY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| ROCKVILLE | RESIDENCE (as below) | | | HOUSEWIFE | | | - - - | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| MARYLAND | | MONTGOMERY | | ROCKVILLE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 2880 GLENORA LA, XXX | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| EDWARD - - - SCHOENBACH | | | | ROSE - - - LEVINE | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| NO | | | | 116-14-9295 | | NORMAN KARSH (HUSBAND) (SAME AS ABOVE) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinomatosis</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Malignant Pheochromocytoma</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>1940</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>8 months</u>
<u>8 months</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET | | CITY OR TOWN | | COUNTY STATE | |
| | | | | | | | | | |
| 22a. I certify that <u>we</u> (hospital) attended the deceased from <u>June 9, 1964</u> to <u>April 20, 1980</u> , that <u>we</u> (we) lost
saw the deceased alive on <u>April 10, 1980</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated
above, (1) <u>we</u> (I) (we) (I) (we) (I) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Stephen C. Cromwell, MD</u> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
<u>4-21-80</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
STEVEN CROMWELL | | | | 22e. ADDRESS
615 MONTGOMERY AVE., ROCKVILLE, MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| CREMATION | | 4-23-80 | | FT. LINCOLN | | BRENTWOOD, P.G., MD. | | | |
| 24. FUNERAL DIRECTOR
DANZANSKY-GOLDBERG MEM. CHAPEL, ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| ROCKVILLE, MD. | | | | APR 28 1980 | | <u>Anthony McCready</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|--|--|--|---|---|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | 8010707
REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Dorothy R. Keach | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
4-10-80 | | | 2b. HOUR
10:30 PM | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
3 23 1877 | | 6. AGE (IN YEARS LAST BIRTHDAY)
103 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Rhode Island | | 7c. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Wheaton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Wheaton Manor Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Sil. Spr. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
C. A. L. Richards | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mary W. Wiltbank | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
179-36-1205 | | 17. INFORMANT
Mary K. Hoisington | | ADDRESS
10800 Ga. Ave. Sil. Spr., Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) extreme cachexia
4409
DUE TO, OR AS A CONSEQUENCE OF (b) generalized arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 month
1 year | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 66 to 4-10-80, that (I) lost saw the deceased alive on 4-7-80, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
George H. Sengstack MD
DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | 22c. DATE SIGNED
4-11-80 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
George H. Sengstack | | | | | | 22e. ADDRESS
9241 Columbia Blvd. S. S., Md. 20810 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | | 23b. DATE
4/11/80 | | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Alexandria, Va. | | | |
| 24. FUNERAL DIRECTOR NAME
Warner E. Pumphrey, Inc. | | | | | | 25a. DATE REC'D. BY REGISTRAR
APR 15 1980 | | 25b. REGISTRAR'S SIGNATURE
M. J. McCreedy | | |
| ADDRESS
8434 Ga. Ave. Sil. Spr., Md. | | | | | | | | | | |



3206
BP
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8010708 | |
|--|--|---|--|--|---|---|--|---|-----------------------------------|--|--|
| 1. FOR STATE REGISTRAR | | | REG. NO. | | | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT)
Ada L. Kennedy | | | 2a DATE OF DEATH
4 20 80 | | | 2b HOUR
11:40 ^p | | | | | |
| 3 SEX
female | | 4 RACE
white | | 5 DATE OF BIRTH
11 17 07 | | 6 AGE (IN YEARS LAST BIRTHDAY)
72 | | 7 IF UNDER 1 YEAR
MONTHS DAYS | | 8 IF UNDER 24 HRS
HOURS MIN | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
West Virginia | | 7b CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10 CITY OR TOWN OF DEATH
Silver Spring | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b KIND OF BUSINESS OR INDUSTRY
Home | | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13b STATE
Maryland | | | | | | | | | | 13c CITY OR TOWN
Silver Spring | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Lacey Cochran | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary E. McKinney | | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
no | | | | | |
| 16b SOCIAL SECURITY NO.
231 62 1857 | | | 17 INFORMANT
ADDRESS Silver Spring, Md.
Randolph Kennedy 2300 Greenery Ln. | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <i>Carcinoma of colon with metastases</i>
1539 DUE TO, OR AS A CONSEQUENCE OF (b) <i>2 yrs</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (c)
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <i>4/17/80</i> to <i>4/20/80</i> , that (I) (we) lost the deceased alive on <i>4/20</i> , 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b SIGNATURE
<i>Myron L. Lenkin</i> | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c DATE SIGNED
<i>4/21/80</i> | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
Myron L. Lenkin | | | 22e ADDRESS
2309 Shorefield Rd. Wheaton, Md. 20902 | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)
C Cremation | | | 23b DATE
4/21/80 | | 23c NAME OF CEMETERY OR CREMATORY
Metropolitan | | | 23d LOCATION
Alexandria Fairfax Va. | | | |
| 24 FUNERAL DIRECTOR'S NAME
Tyson Wheeler Funeral Home, Inc.
1331 Rockville Pike Rockville, Md. 20852 | | | | | | 25a DATE REC'D. BY REGISTRAR
APR 28 1980 | | 25b REGISTRAR'S SIGNATURE
<i>Anthony McCready</i> | | | |

2:11

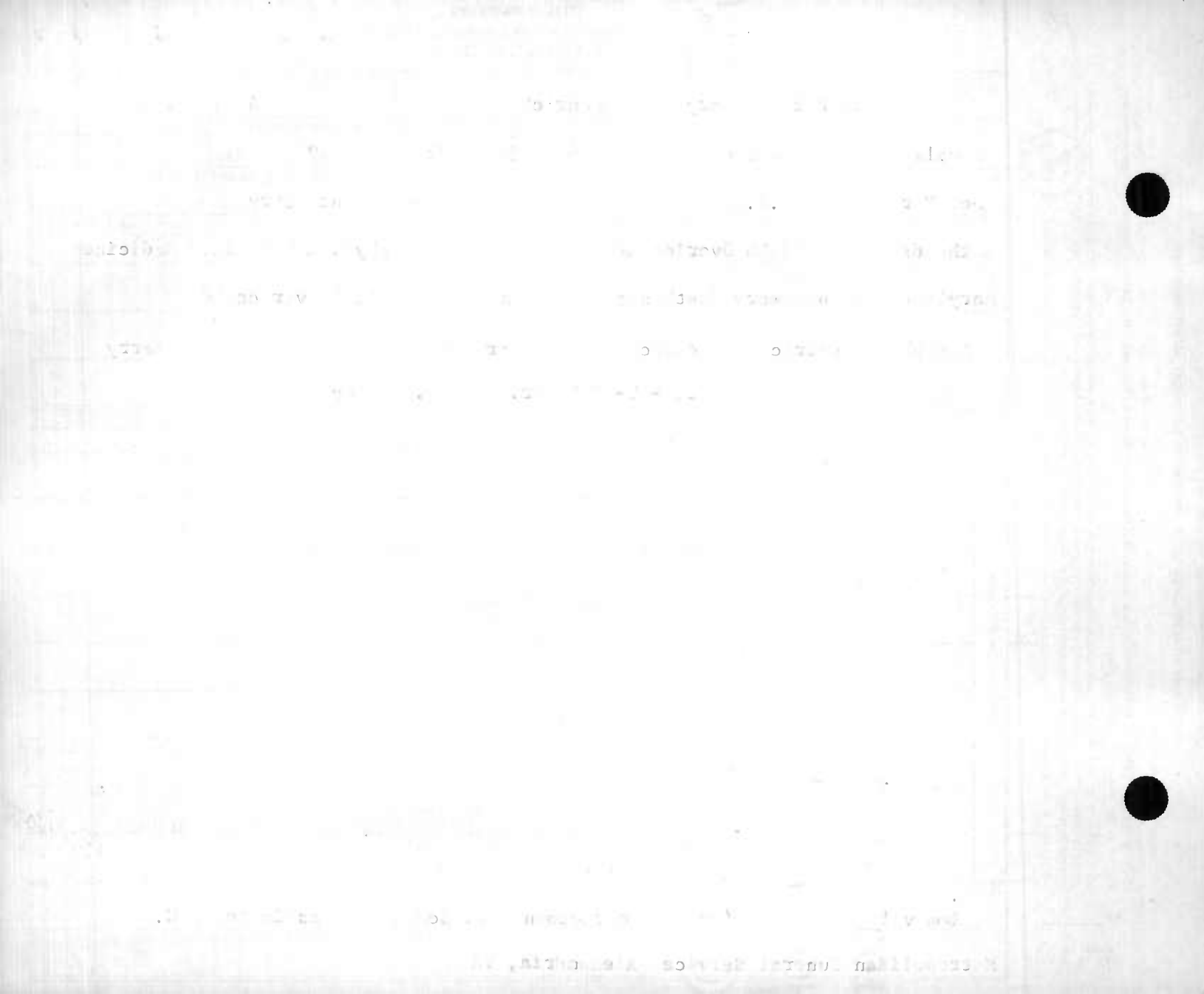
79

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

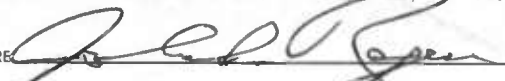
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

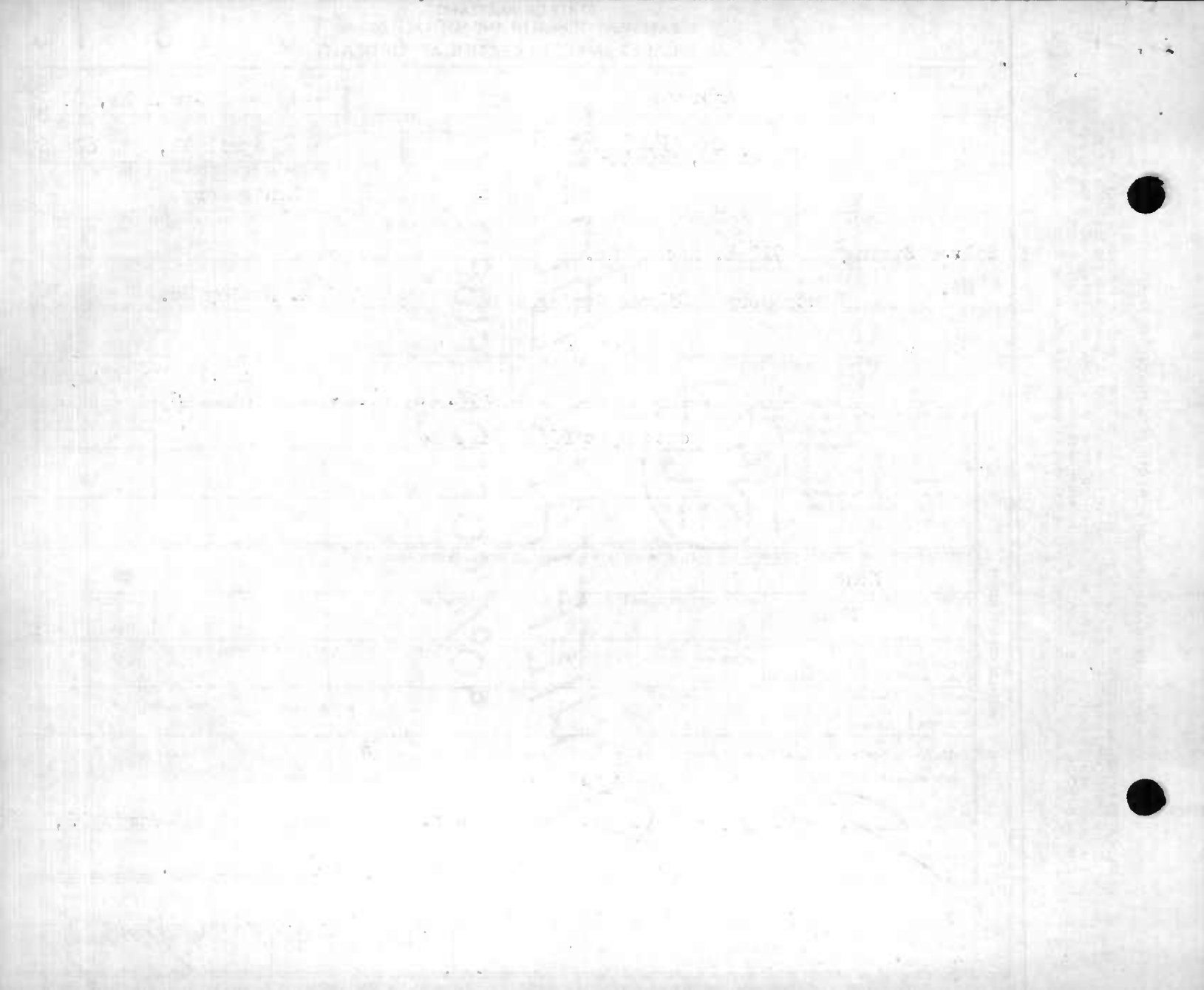
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 0 1 0 7 0 9 | | | |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) Margaret Mary Kenrick | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
4 19 1980 | | 2b. HOUR
M | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
6 21 1920 | | 6. AGE (IN YEARS LAST BIRTHDAY)
59 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
6108 Overlea Rd. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Phys. Rehabilit. | | 12b. KIND OF BUSINESS OR INDUSTRY
Medicine | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Bethesda | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
6108 Overlea Rd. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph Patrick Kenrick | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Margaret Barry | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO
(IF YES, GIVE WAR OR DATES)
111-22-3204 | | 17. INFORMANT ADDRESS
Dr. Paul V. Wooley III | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RESPIRATORY FAILURE
1729
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC MALIGNANT MELANOMA
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 DAY
4 YEARS | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
NONE | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22. I certify that (I) (this hospital) attended the deceased from AUGUST 15 19 79 to APRIL 19 19 80 , that (I) (we) last saw the deceased alive on APRIL 19 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I (we) did not view the body after death.) | | | | | | | |
| 22b. SIGNATURE
Paul V. Wooley | | | | DEGREE
MD | | 22c. DATE SIGNED
APRIL 19, 1980 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
PAUL V WOOLLEY MD | | | | 22e. ADDRESS
GEORGETOWN UNIVERSITY HOSPITAL, WASHINGTON DC | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Removal | | 23b. DATE
4/19/80 | | 23c. NAME OF CEMETERY OR CREMATORY
Georgetown Med. School | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington D C. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Metropolitan Funeral Service Alexandria, VA | | | | 25a. DATE REC'D. BY REGISTRAR
APR 23 1980 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 10710 | | | |
|--|--|------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1- STATE REGISTRAR | | | | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Joseph Ambrose Kiley | | | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR April 11, 80 | | 2b. HOUR OF ESTI- MATED 600 P M | |
| 3. SEX M | | 4. RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR March 30, 1892 | | 6. AGE (IN YEARS LAST BIRTHDAY) 78 | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN | | 2c. DATE PRONOUNCED DEAD April 11, 19 80 | | 2d. HOUR 600 P M | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Minnesota | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 712 E. Notley Rd. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Attorney | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Md. | | | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Silver Spring | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 712 E. Notley Rd. | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Thomas Kiley | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Hickey | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. YES | | 17. INFORMANT ADDRESS Jennie Niles 11811 Caplinger Rd. Sil. Spr., Md. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Disease
4291
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).
None | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION None | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE  | | | | | | TITLE (SPECIFY) Dep. MEDICAL EXAMINER | | | | DATE SIGNED April 12, 1980 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers | | | | | | ADDRESS Silver Spring, Maryland | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 4/15/80 | | 23c. NAME OF CEMETERY OR CREMATORY St. John Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Forest Glen, Maryland | | | | | |
| 24. FUNERAL DIRECTOR NAME Warner E. Pumphrey, Inc. | | | | | | 25a. DATE REC'D. BY REGISTRAR (THE RECORDS SECTION) | | | | APR 17 1980 | | | | | |

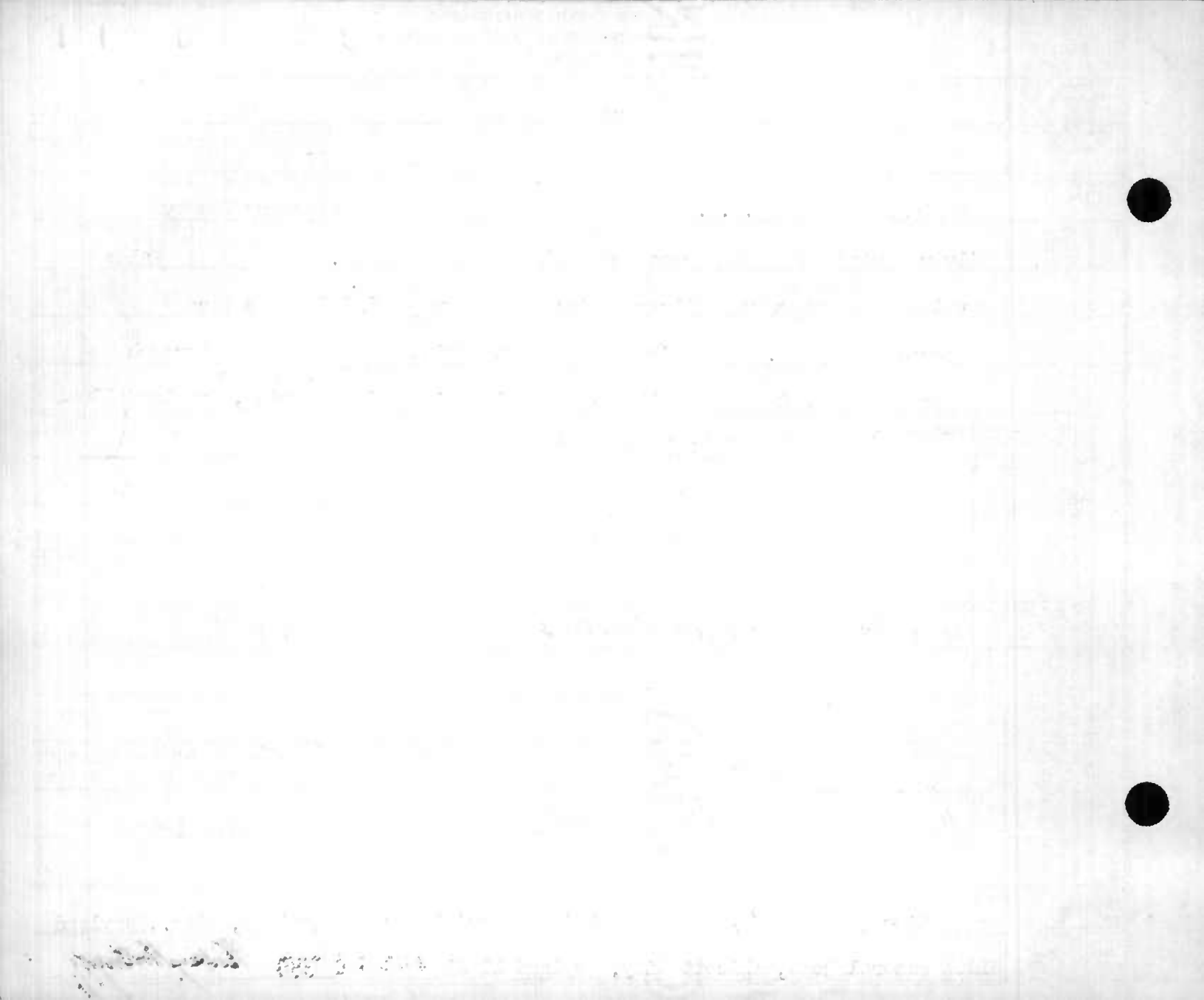


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8010711 | |
|---|--|--|---|--|--|--|--|--|--|--|--|
| 1. FOR
STATE
REGISTRAR | | | REG. NO. | | | | | | | | |
| 1 DECEASED NAME
(TYPE OR PRINT) | | | FIRST
James | | | MIDDLE
Herbert | | | LAST
King | | |
| 2a DATE OF DEATH | | | MONTH
4 | | | DAY
4 | | | YEAR
80 | | |
| 2b HOUR
8:19 PM | | | 3 SEX
Male | | | 4 RACE
W | | | 5 DATE OF BIRTH
MONTH
06
DAY
21
YEAR
24 | | |
| 6 AGE (IN YEARS LAST BIRTHDAY)
55 YRS. | | | 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | 10 CITY OR TOWN OF DEATH
Silver Spring | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Eng. | | |
| 12b KIND OF BUSINESS OR INDUSTRY
Sales | | | 13a STATE
Maryland | | | 13b COUNTY
Montgomery | | | 13c CITY OR TOWN
Silver Spring | | |
| 14 FATHER'S NAME
FIRST
George | | | MIDDLE
L. | | | LAST
King | | | 15 MOTHER'S MAIDEN NAME
FIRST
Catherine | | |
| MIDDLE
Gorsuch | | | LAST
Gorsuch | | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
yes | | | 16b SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW 2 | | |
| 17 INFORMANT
Evelyn King | | | 18 ADDRESS
12505 Waldo Lane | | | 19 ADDRESS
Silver Spring, Maryland | | | 20 ADDRESS
20904 | | |
| 11 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>HEPATIC FAILURE</u>
1579
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
DUE TO, OR AS A CONSEQUENCE OF (b) <u>METASTATIC CARCINOMA</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>CARCINOMA - PANCREAS</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 DAYS
UNKNOWN
UNKNOWN - 2 mo. | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a) | | | | | | | | | | | |
| 19a DATE OF OPERATION
4-2-80 | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED
CARCINOMATOSIS | | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>3-5</u> , 19 <u>80</u> , to <u>4-4</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>4-4</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b SIGNATURE
Richard L. Cohen | | | 22c DEGREE
MD | | | 22d ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22e DATE SIGNED
4-5-80 | | |
| 22f PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22g ADDRESS | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)
cremation | | | 23b DATE
4/8/80 | | | 23c NAME OF CEMETERY OR CREMATORY
Westview Memorial Park | | | 23d LOCATION
CITY OR TOWN COUNTY STATE
Catonsville, Balto., Maryland | | |
| 24 FUNERAL DIRECTOR
NAME
SLACK Funeral Home, Ellicott City, Maryland | | | 24b ADDRESS
21043 | | | 25a DATE REC'D. BY REGISTRAR
APR 10 1980 | | | 25b REGISTRAR'S SIGNATURE
[Signature] | | |

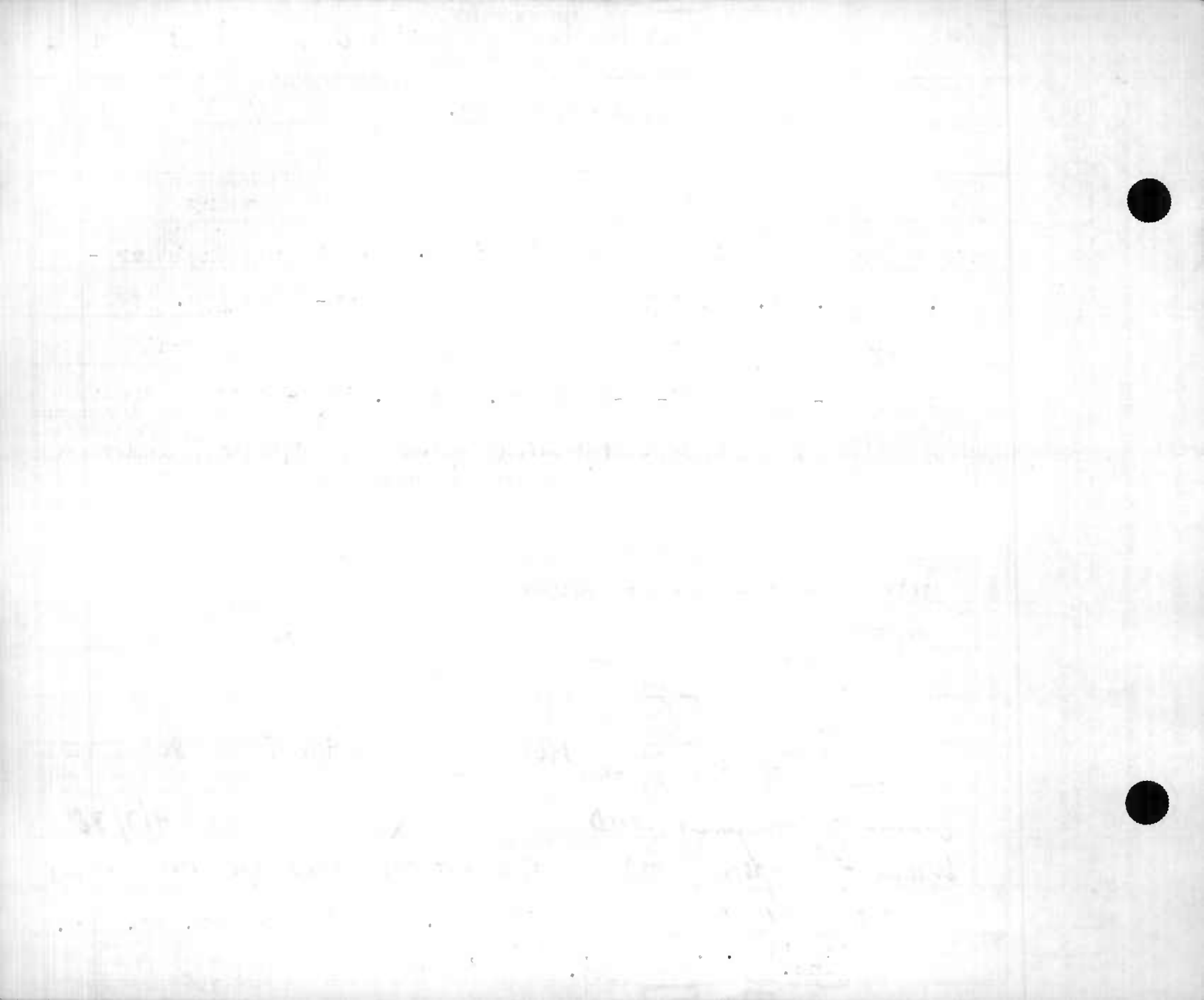


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 0 1 0 7 1 2 | | |
|--|--|---|---|---|--|--|---|--|---|--|----------------------------------|--|
| 1- FOR STATE REGISTRAR | | | | | REG. NO. | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
JOSEPH ANDREW KING. Sr. | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
4 7 1980 | | | 2b. HOUR
12 31 A M | | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
I 29 1895 | | | 6. AGE (IN YEARS LAST BIRTHDAY)
85 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS | | 7b. IF UNDER 24 HRS
HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Wash. DC. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | | | | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hosp. | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Stationary Engineer - | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE 13b. COUNTY 13c. CITY OR TOWN
Md. Pr. Geo. Chillum | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
5800- 15th Ave. | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Henry King | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Rufina Horning | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
- | | 17. INFORMANT ADDRESS
Mrs. Helen R. King - above address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 492- Chronic obstructive pulmonary disease, severe, & emphysema
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
(c) _____
DUE TO, OR AS A CONSEQUENCE OF Severe, & emphysema
DUE TO, OR AS A CONSEQUENCE OF _____
DUE TO, OR AS A CONSEQUENCE OF _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
Arteriosclerotic heart disease | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
under 1 year | | |
| MEDICAL CERTIFICATION | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
N/A | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
- | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
N/A | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 1960, 19 to Apr 7, 1980, that (I) (we) last saw the deceased alive on Apr 6, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
William F. Simpson, MD | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
4/7/80 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
William F. Simpson, MD | | | | | 22e. ADDRESS
8106 N.H. Ave, Silver Spr. Md. 20903 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
4/10/1980 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cem. | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Suitland Pr. Geo. Md. | | | | |
| 24. FUNERAL DIRECTOR
NAME
Nalley's F.H. Inc. | | | | | ADDRESS
Mt. Rainier, Md. | | 25a. DATE REC'D. BY REGISTRAR
APR 15 1980 | | 25b. REGISTRAR'S SIGNATURE
Hickey McCreedy | | | |



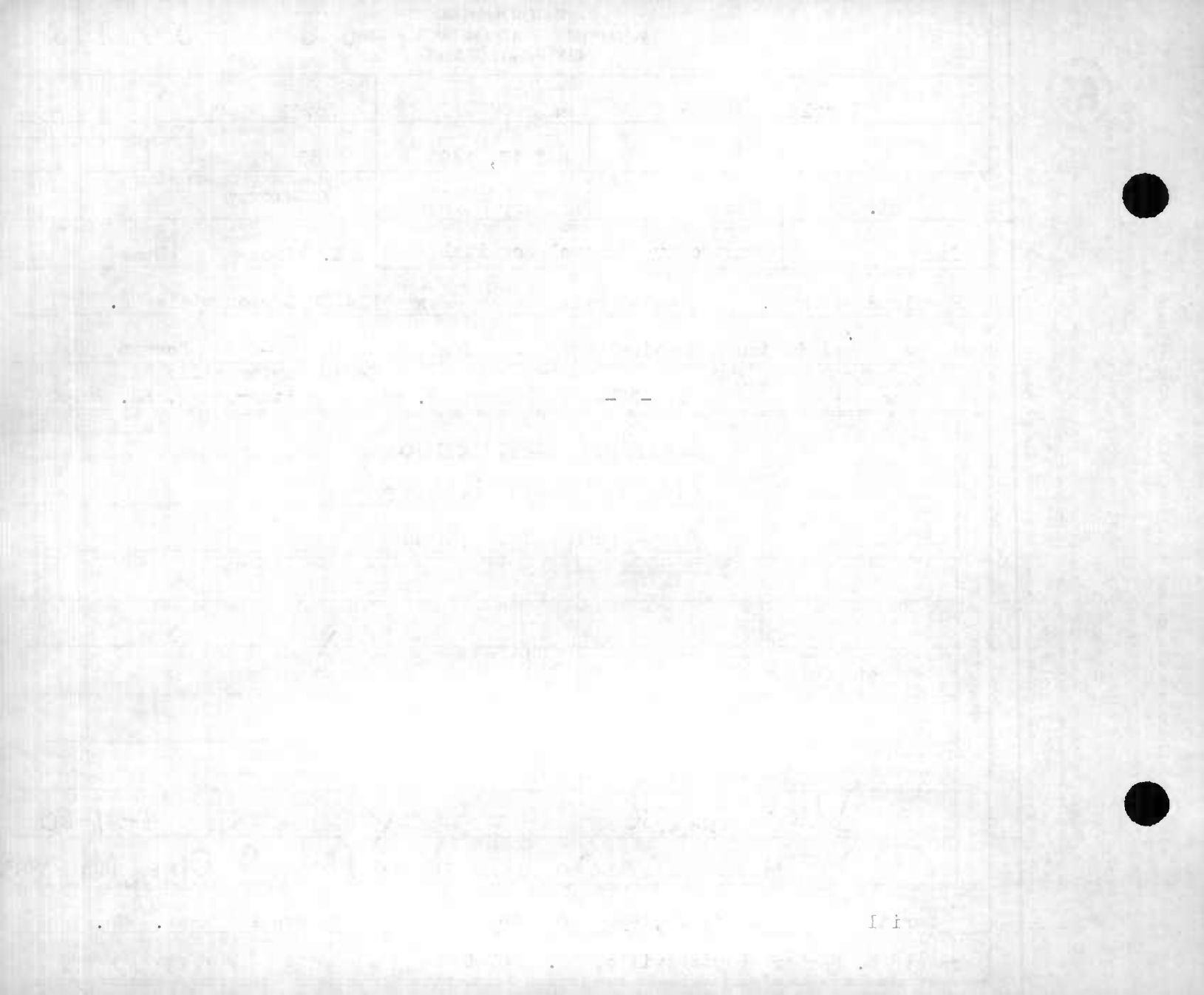
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

B 0 1 0 7 1 3

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|--|--|---|--|--|--|--|---|--|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT) Pearle GREEN King | | | 2a. DATE OF DEATH MONTH DAY YEAR
April 20, 1980 | | | 2b. HOUR
4:00AM | | | | |
| 3 SEX
FEMALE | | 4 RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
MAY 17, 1896 | | 6 AGE (IN YEARS LAST BIRTHDAY)
83 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
H. Wife | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
Mont. | | 13c. CITY OR TOWN
Gaithersburg | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
24220 Laytonsville Rd. | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
George Washington Hawkins | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ida - Bowman | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | | 16b. SOCIAL SECURITY NO.
217-32-4697 | | 17 INFORMANT
24210 Laytonsville Rd.
Thomas R. King Gaithersburg, Md. 20760 | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Ischemia
4409
DUE TO, OR AS A CONSEQUENCE OF
1b) Chronic Heart Failure
DUE TO, OR AS A CONSEQUENCE OF
1c) Atherosclerotic Disease | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death | | | | | | | | | | |
| 22b. SIGNATURE
J. Minarcik | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
4-21-80 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
J. Minarcik, MD | | | | 22e. ADDRESS
18101 Prince Philip Dr. Olney, Md 20853 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
April 23, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY
Damascus | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Damascus Mont. Md. | | | |
| 24 FUNERAL DIRECTOR
NAME
Francis H. Barber | | | | | ADDRESS
Laytonsville, Md. 20760 | | 25a. DATE REC'D. BY REGISTRAR
APR 23 1980 | | 25b. REGISTRAR'S SIGNATURE
H. H. H. H. H. | |

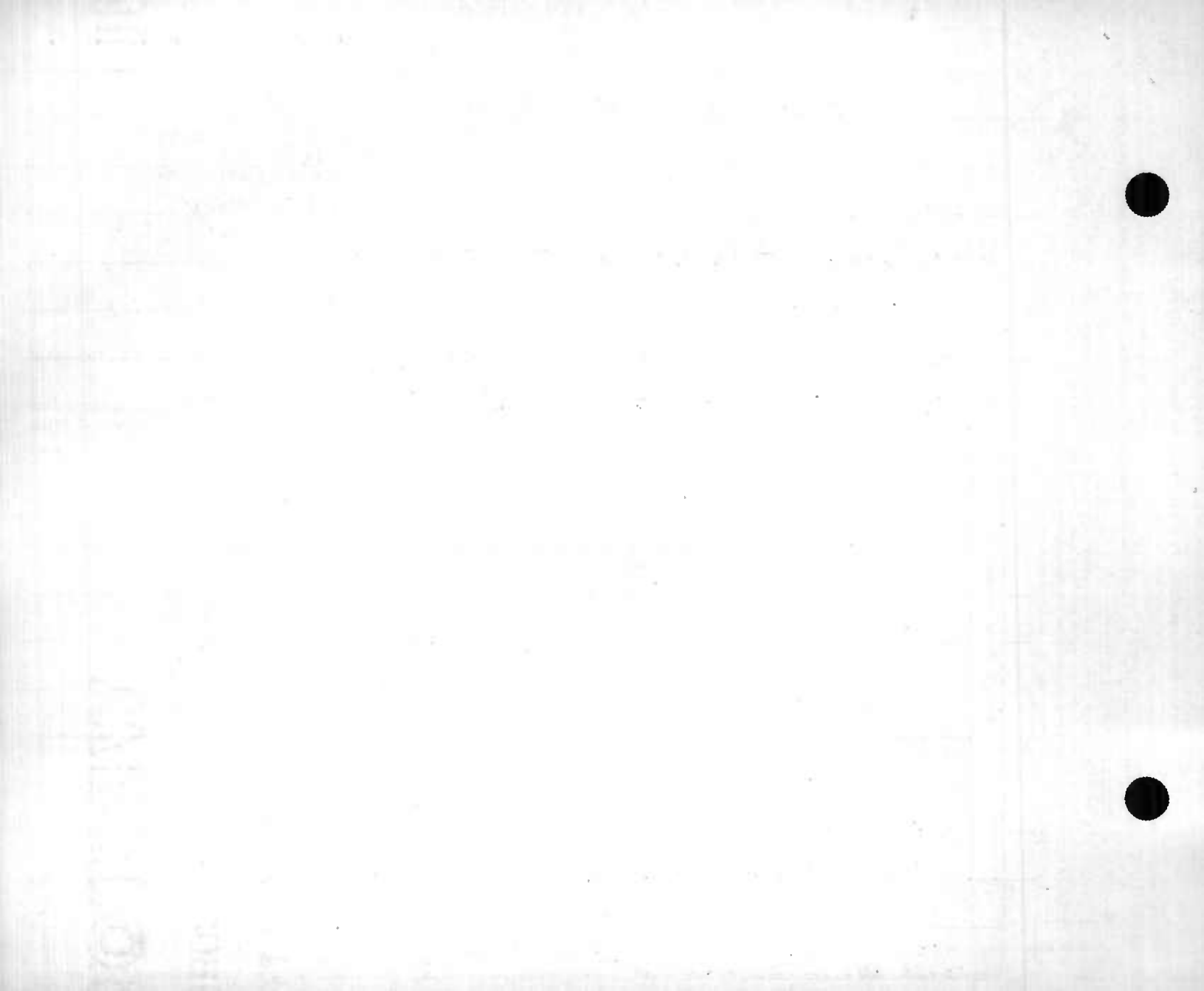


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8010719 | | |
|---|--|---------|---|------------------|------------------------------------|---|--|-----------------|--|-----------------|-----------------------------------|--|
| FOR
1. STATE
REGISTRAR | | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE OF DEATH | | | MONTH DAY YEAR | | 2b. HOUR | |
| Raymond A King | | | | | | ARR 23 1980 | | | | | 2:14 PM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | |
| Male | | White | | Aug. 22 1910 | | 69 yrs | | MONTHS DAYS | | HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Washington, DC | | | USA | | | | | | Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Silver Spring | | | Holy Cross Hospital | | | | | | Retired | | Brake Service | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 13b. STATE | | | 13c. CITY OR TOWN | | | 13d. STREET ADDRESS | | | |
| Maryland | | | Montgomery | | | Sil. Spring | | | 10421 Inwood Avenue, | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | |
| Richard A King | | | Mary E Taylor | | | no | | | 577-05-7550 | | | |
| 17. INFORMANT (wife) | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Anemia</u>
1541
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) <u>Amorhagic Neutrophilia</u>
(c) <u>Chronicity of Pectus</u> | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>diabetes mellitus</u> | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2:20 pm</u> 19 <u>80</u> to <u>2:30 pm</u> 19 <u>80</u> , that (I) (we) lost
saw the deceased alive on <u>2:30 pm</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE | | | 22c. DATE SIGNED | | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | |
| Thomas P. Fogarty, MD. | | | 23 Apr 80 | | | Attending Physician <input checked="" type="checkbox"/> Medical Director <input type="checkbox"/> Staff Physician <input type="checkbox"/> | | | 7676 N.H. Ave., Langley Park, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | | 4-26-1980 | | Cedar Hill Cemetery | | Suitland Pr. Georges Md. | | | | | |
| 24. FUNERAL DIRECTOR | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | |
| Warner E. Pumphrey, Jr. | | | APR 23 1980 | | | [Signature] | | | | | | |
| 8434 Ga. Ave., S.S. Md. | | | | | | | | | | | | |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1201

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | | | |
|--|--|--|---|---|--|---|--|---|--|
| 1. DECEASED-NAME
(Type or print) CONSTANCE DIANE KISSAL | | | 2a. DATE OF DEATH
Month APRIL Day 29 Year 1980 | | | 2b. HOUR
7:30 A.M. | | | |
| 3. SEX
FEMALE | | 4. RACE
White | | 5. DATE OF BIRTH
Aug. 18, 1918 | | 6. AGE (In years last birthday)
61 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Wash., D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
11007 Schuylkill Road | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
11007 Schuylkill Road | |
| 14. FATHER'S NAME
First George Middle L. Last Chipouras | | | 15. MOTHER'S MAIDEN NAME
First Garafalia Middle Last Malas | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown No (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
579 05 5152 | | 17. INFORMANT
Julie-Felecia Kendros | | Address
Same As #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) WIDELY METASTATIC BREAST CANCER
1749
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 1/2 yrs | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from AUGUST, 1978 , to APRIL 29, 1980 , that (I) (we) last saw the deceased alive on MARCH 7, 1980 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Daniel Rosenblum DEGREE | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
4/29/80 | | | |
| 22d. PHYSICIAN'S NAME (Type)
DANIEL ROSENBLUM | | | | 22e. ADDRESS
10400 CONNECTICUT AV KENSINGTON, MD 20795 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
May 1, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Brentwood, P.G. Md. | | | |
| 24. FUNERAL DIRECTOR
Hines/Rinaldi Funeral Home | | | | ADDRESS
11800 New Hamp. Ave. S.S. Md. | | 25a. REC'D BY REGISTRAR
MAY 1 1980 | | 25b. REGISTRAR'S SIGNATURE
Anthony M. Chedy | |

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | |
|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) GRACE HOPKINS KLEIN | | 2a. DATE OF DEATH MONTH DAY YEAR
April 23, 1980 | | 2b. HOUR
9:10 A.M. | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
FEB. 28, 1901 | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 74 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | 10. CITY OR TOWN OF DEATH
TAKOMA PARK | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
WASHINGTON ADVENTIST HOSPITAL | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
FEDERAL GOVT. | | 12b. KIND OF BUSINESS OR INDUSTRY
(RETIRED) | | 13a. STREET ADDRESS
500 LINCOLN AVENUE | |
| 13b. COUNTY
Mont. | | 13c. CITY OR TOWN
Takoma Park | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
ROBERT HOPKINS | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
SUE DEVER | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | |
| 16b. SOCIAL SECURITY NO.
579-22-9984 | | 17. INFORMANT
HELEN V. HOPKINS | | ADDRESS
420 Boyd AVE T.P. MD | |

| | | | |
|---|--|--|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Ventricular Tachycardia
DUE TO, OR AS A CONSEQUENCE OF
(b) Coronary Atherosclerotic Cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
(c) Myocardial Infarction | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Cholelithiasis, Hypertension, Chronic Bronchitis | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from 4 apr 19 80 to 23 apr 19 80 , that (we) lost the deceased alive on 23 apr 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Thomas P. Fogarty | | 22c. DATE SIGNED
4/23/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Thomas P. Fogarty | | 22e. ADDRESS | |

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
April 26, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Dilly Spring Md. | |
| 24. FUNERAL DIRECTOR
William Walters | | 25a. ADDRESS
254 Carroll St NW Washington D.C. 20012 | | 25b. DATE OF REGISTRATION
APR 28 1980 | | 25c. REGISTRAR'S SIGNATURE
[Signature] | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8010717

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Ella M Knapp | | | 2a. DATE OF DEATH
MONTH DAY YEAR
4 4 80 | | | 2b. HOUR
2130 M | | | |
| 3 SEX
Female | | 4 RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
3 17 93 | | 6. AGE (IN YEARS LAST BIRTHDAY)
87 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Nebraska | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Adventist Hosp | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
MD | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John J. Lyon | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Elizabeth Cole | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | | | 16b. SOCIAL SECURITY NO.
479-46-8504 | | 17. INFORMANT
ADDRESS
E. LaVaughn Conklin, Same as #13 | | | |

| | | | | | | | | | | |
|---|--|--|--|--|--|--|--|---|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) <u>pulmonary edema</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>congestive heart failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>atherosclerotic cardiovascular disease</u> | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<u>pneumonia</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>4/2</u> 19 <u>80</u> , to <u>4/4</u> 19 <u>80</u> , that (1) (we) last saw the deceased alive on <u>4/4</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>S. J. Dolansky</u> | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>4/5/80</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>S. J. Dolansky</u> | | | | | | 22e. ADDRESS
<u>15 E Decr Pk Dr Gzithersburg Md</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
4/9/80 | | 23c. NAME OF CEMETERY OR CREMATORY
Graceland Cemetery | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Creston, Iowa | | |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland | | | | | | 25a. DATE REC'D. BY REGISTRAR
APR 9 1980 | | 25b. REGISTRAR'S SIGNATURE
<u>L. H. H. H.</u> | | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO HOSPITALS: ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 0 1 0 7 1 8 | |
|---|--|---|--|--|--|--|--|---|--|--|--|
| FOR
1 - STATE
REGISTRAR | | | | CERTIFICATE OF DEATH | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | |
| FIRST MIDDLE LAST
Albert M Knoblock | | | | MONTH DAY YEAR
4 27 80 | | | | 6 43 AM | | | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| male | | white | | MONTH DAY YEAR
12 12 14 | | 65 YRS | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Indiana | | USA | | | | Montgomery MD. | | | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Bethesda | | Suburban Hosp. | | | | | | retired | | self-empl. | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13a. INSIDE CITY LIMITS? | | | | 13b. STREET ADDRESS | | | |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN
Maryland Montgomery Rockville | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 12407 Village Sq. Terr. #201 | | | |
| 14 FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| FIRST MIDDLE LAST
Oscar Knoblock | | | | FIRST MIDDLE LAST
Venna L. Sellers | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | 16b. SOCIAL SECURITY NO. | | 17 INFORMANT ADDRESS | | | | | |
| no | | | | 384-09-2059 | | 5407 Woodbine Rd.
Albert M. Knoblock, Jr. Woodbind, Md. | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Metastatic Rectal Carcinoma</u>
1541
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
months | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/27/80</u> to <u>4/27/80</u> , that (I) <u>was</u> last saw the deceased alive on <u>4/26/80</u> and that in my <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (If not, so qualified) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Stephen J. Newman</u>
DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | | 22c. DATE SIGNED
4/27/80 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Stephen J. Newman | | | | | | | | 22e. ADDRESS
5411 W. Cedar Lane Bethesda, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| Burial | | | | 4/30/80 | | Winfield Cemetery | | Woodbine Maryland | | | |
| 24 FUNERAL DIRECTOR
NAME
Ryerson Wheeler Funeral Home, Inc.
1331 Rockville Pike Rockville, Maryland | | | | | | | | 25a. DATE REC'D. BY REGISTRAR
APR 30 1980 | | 25b. REGISTRAR'S SIGNATURE
<u>Robert McCreedy</u> | |

APR 20 1944

12

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11/2/40

~~11/2/40~~

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
LUCILLE MARIA KRAFT | | | 2a. DATE OF DEATH
MONTH DAY YEAR
4 23 80 | | | 2b. HOUR
7:10 P.M. | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
March 2, 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY)
70 Years YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington, D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH
OLNEY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
MONTGOMERY GENERAL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Beautician | | 12b. KIND OF BUSINESS OR INDUSTRY
Beauty Shop | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
Md. | | 13b. COUNTY
Mont. | | 13c. CITY OR TOWN
Brinklow | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
#9 Pinebark Court | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph Abell | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Jessie Bowles | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
None | | 17. INFORMANT (Son)
Richard Kraft | | ADDRESS
#9 Pinebark Court, Md. | | | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Multiple Myeloma</u>
2030
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3-4 yrs. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:
<u>Numerous fractures resistant to therapy, hypercalcemia</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19 <u>79</u> , to <u>23 Apr</u> , 19 <u>80</u> , that (I) (we) lost the deceased alive on <u>23 Apr</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, state) (did not view the body after death.) | | | | | | | | | |
| 22b. SIGNATURE
<u>Donald E. Dillon</u> MD | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
24 Apr 80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Donald E. Dillon | | | | 22e. ADDRESS
18111 Prince Philip Dr., Olney, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Apr. 28, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arlington Va. | | | |
| 24. FUNERAL DIRECTOR
NAME
Hines/Rinaldi F.H. 11800 New Hamp. Ave. S.S.Md. | | | | 25. DATE REC'D. BY REGISTRAR
APR 28 1980 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | |

CHITREXIA W. DOWD

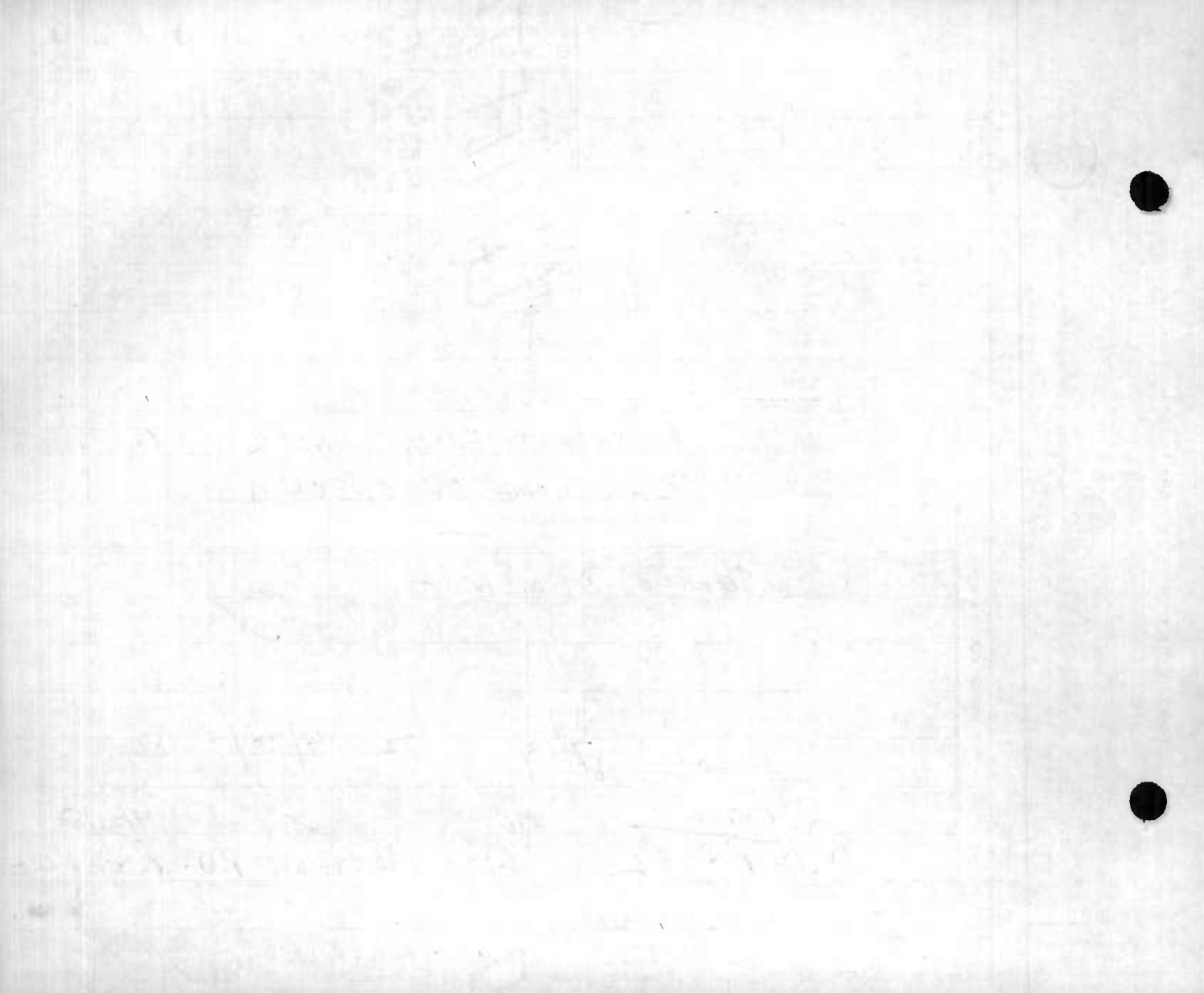
20X COLUMN 16

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of such.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|---|--|---|--|--|--|---|--|---|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. 10720 | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
<i>Dora Kraemer</i> | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
<i>4 20 80</i> | | | 2b. HOUR
<i>10²⁸ P.M.</i> | | |
| 3 SEX
<i>FEMALE</i> | | 4 RACE
<i>CAUCASIAN</i> | | 5 DATE OF BIRTH MONTH DAY YEAR
<i>MAY 10, 1885</i> | | 6 AGE (IN YEARS LAST BIRTHDAY)
<i>94</i> YRS | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>RUSSIA</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery</i> MD. | | | | |
| 10 CITY OR TOWN OF DEATH
<i>Rockville</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>HEBREW HOME OF GREATER WASH.</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>MERCHANT</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>STORE GENERAL</i> | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
<i>MARYLAND</i> | | | | | 13b. COUNTY
<i>MONTGOMERY</i> | | 13c. CITY OR TOWN
<i>SILVER SPG.</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
<i>BAERL HORNSTEIN</i> | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
<i>PEARL</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
<i>NO</i> | | | | | 16b. SOCIAL SECURITY NO.
<i>054-09-2811</i> | | 17 INFORMANT ADDRESS
<i>MRS PAULA MINER BOX 1406 ORLEANS, MASS.</i> | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>1534 META STASIS FROM CANCER</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }
DUE TO, OR AS A CONSEQUENCE OF (b) <i>CARCINOMA OF CAECUM</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>—</i>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>ONE MONTH</i> | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<i>SENILE DEMENTIA</i> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
<i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>7/13/72</i> to <i>4/30/80</i> , that (I) (we) lost the deceased alive on <i>4/30/80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<i>D.D. Patel</i> | | | DEGREE
<i>MD.</i> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL STAFF <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
<i>4/21/80</i> | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>D.D. PATEL</i> | | | 22e. ADDRESS
<i>6121 MONTRUSE RD. ROCKVILLE</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>BURIAL</i> | | | 23b. DATE
<i>APR. 21, 80</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>KING DAVID CEM.</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE
<i>FALLS CHURCH FAIRFAX VA.</i> | | | |
| 24. FUNERAL DIRECTOR NAME
<i>DANZANSKY-GOLDBERG MEMORIAL CHAPELS</i> | | | ADDRESS
<i>ROCKVILLE, MD.</i> | | 25a. DATE REC'D. BY REGISTRAR
<i>APR 28 1980</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Anthony McCreedy</i> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|---|--|---|--|---|---|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | 8 0 1 0 7 2 1 | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) James Hughes Kronmeyer | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 4/19/80 | | | 2b. HOUR 11:30 PM | |
| 3. SEX MALE | | 4. RACE Cauc. | | 5. DATE OF BIRTH MONTH DAY YEAR 1/25/09 | | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Research Tech. | | 12b. KIND OF BUSINESS OR INDUSTRY Telephone Co | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13a. STREET ADDRESS | | | | |
| 13a. STATE Md. | | 13b. COUNTY Montg. | | 13c. CITY OR TOWN Rockville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 4721 Boiling Brook Pkwy. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Frederick C. Kronmeyer | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillie Mae Hill | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 066-09-1326 | | 17. INFORMANT ADDRESS Elizabeth J. Kronmeyer (Same as 13e) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) SEPSIS - RENAL FAILURE | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3-4 WEEKS | |
| 1520 } DUE TO, OR AS A CONSEQUENCE OF (b) STATUS Post-OP "WHIPPLE" | | | | | | | | 2 1/2 MOS. | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) CARCINOMA DUODENUM | | | | | | | | 8 MOS. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION 2-6-80 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA DUODENUM | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from FEB 3 , 19 80 , to APRIL 19 , 19 80 , that (I) (we) lost saw the deceased alive on APRIL 19 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Ira Miller M.D. | | | | DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 4-20-80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) IRA MILLER | | | | 22e. ADDRESS 8218 Wisconsin Ave. Bethesda Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 4-23-80 | | 23c. NAME OF CEMETERY OR CREMATORY Parklawn Mem. Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Md. | | | |
| 24. FUNERAL DIRECTOR NAME Robert A. Pumphrey | | | | 25. DATE REC'D BY REGISTRAR APR 28 1980 | | 26. REGISTRAR'S SIGNATURE [Signature] | | | |
| Homes, P.A., Bethesda, Md. | | | | | | | | | |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|---|--|---|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | REG. NO. | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
Hanna Y. Kwiatkowski | | | 2a. DATE OF DEATH
MONTH DAY YEAR
April 1, 1980 | | | | 2b. HOUR
10:02 P.M. | | | |
| 3. SEX
female | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
June 10, 1906 | | 6. AGE (IN YEARS LAST BIRTHDAY)
73 YRS | | 7. # UNDER 1 YEAR
MONTHS DAYS | | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Poland | | 9. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | |
| 12. CITY OR TOWN OF DEATH
Chevy Chase | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
4701 Willard Avenue | | | | 14. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
art therapist - Prof. | | 15. KIND OF BUSINESS OR INDUSTRY
University | | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Chevy Chase | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
4701 Willard Ave. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Felix Landsberg | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Jadwiga Landau | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
no | | | | |
| 17. SOCIAL SECURITY NO.
058-26-3083 | | | 18. INFORMANT ADDRESS
Alexander J. Kwiatkowski Chevy Chase, Md. | | | | | | | |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Cessation Respiration | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 min | | |
| 1539
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last
(b) Brain metastases | | | | | | | | 5 weeks | | |
| (c) Cancer colon | | | | | | | | 10 years | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1959 , 19____, to 1 April 19 80 , that (I) (we) last saw the deceased alive on 4/1/80 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Milton Gusack, MD | | | DEGREE
MD | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
4/1/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Milton Gusack | | | 22e. ADDRESS
1100 - 22nd St., N. W., Washington, D. C. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
4-3-80 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Suitland, Prince Geo., Maryland | | | | |
| 24. FUNERAL DIRECTOR
NAME
Joseph Gawler's Sons, Inc. | | | | | | 25. DATE REC'D. BY REGISTRAR
APR 8 1980 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | |
| 24. FUNERAL DIRECTOR
ADDRESS
5130 Wisconsin Avenue, N. W., Wash., D. C. | | | | | | | | | | |

TO : DIRECTOR, FBI
FROM : SAC, NEW YORK
SUBJECT: [Illegible]
RE: [Illegible]
[Illegible text block containing several lines of typed information, possibly a memorandum or report header.]

[Large block of illegible text, likely the main body of a letter or report. The text is too faded to transcribe accurately.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 0 1 0 / 2 3 | | | |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Michael J. Lawrence | | | | 2a. DATE OF DEATH MONTH DAY YEAR
April 13, 1980 | | 2b. HOUR
4:45 PM | |
| 3 SEX
male | | 4 RACE
caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
July 6, 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS
76 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Adventist Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Miner | | 12b. KIND OF BUSINESS OR INDUSTRY
Coal | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE 13b. COUNTY
Maryland Montgomery | | | | 13c. CITY OR TOWN
Gaithersburg | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Michael Lawrence | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Unavailable | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO
196011458 | | 17. INFORMANT ADDRESS
Anna Lawrence, Same as 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory failure</u>
505-
DUE TO, OR AS A CONSEQUENCE OF (b) <u>pneumococcal</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 <u>75</u> to <u>4-13</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>4-13</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>D.L. Bucy</u> DEGREE | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
4-13-80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
D.L. Bucy | | | | 22e. ADDRESS
809 Veins Mill Rd Rockville | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
4-16-80 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Mary's Greek Catholic Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Dallas, Pennsylvania | |
| 24. FUNERAL DIRECTOR NAME
ROBERT A. PUMPHREY FUNERAL HOMES, P. A., Rockville, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR
APR 16 1980 | | 25b. REGISTRAR'S SIGNATURE
<u>Jeffrey McCreedy</u> | |

April 13,

My dear Sir,

I have the honor to acknowledge the receipt of your letter of the 10th inst.

Very truly yours,
St. Mary's Creek

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

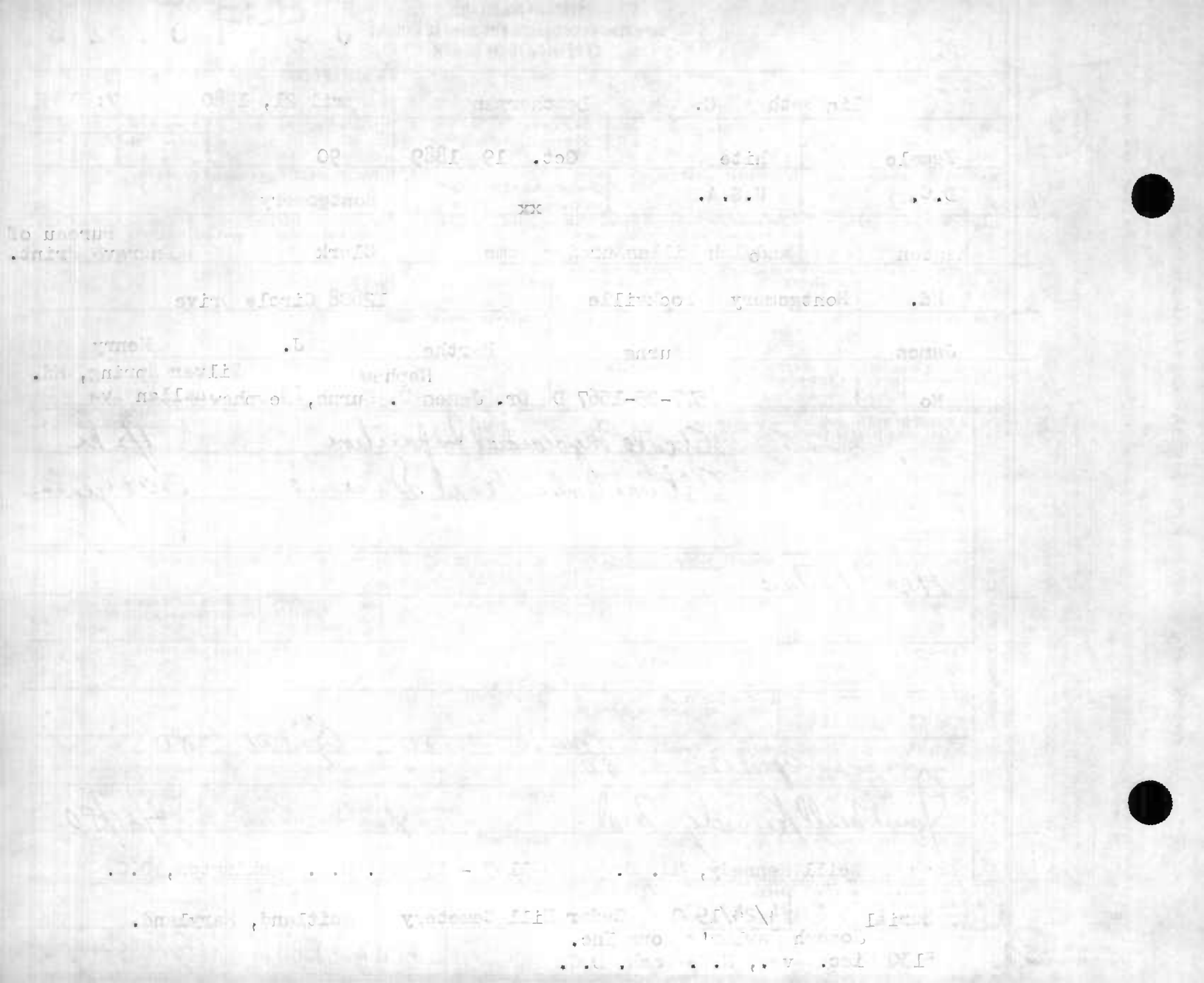
| | | | | |
|--|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT) GEORGIA R. LAWSON | | 2a. DATE OF DEATH
MONTH DAY YEAR
April 8, 1980 | | 2b. HOUR
7 P M |
| 3. SEX
Female | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
June 29, 1895 | | 6. AGE (IN YEARS LAST BIRTHDAY)
84 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Illinois | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. |
| 10. CITY OR TOWN OF DEATH
Boysds | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
20610 Ten Mile Creek Road | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Teacher | 12b. KIND OF BUSINESS OR INDUSTRY
Montgom. Cty. |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Boysds | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James Ballard Osby | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Minnie Brewington | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
578-32-7743 | | 17. INFORMANT
ADDRESS
Boysds, James Lawson, 20610 Ten Mile Creek Rd. Md. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypostatic pneumonia
4029
DUE TO, OR AS A CONSEQUENCE OF
(b) Pneumoperitoneum
DUE TO, OR AS A CONSEQUENCE OF
(c) Chronic perforation of hollow viscus
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Hypertensive cardiovascular disease | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 days
2 months
2 months |
| 19a. DATE OF OPERATION
March 6, 1973 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Chronic perforation of hollow viscus | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from March 6, 1973 to 8 April, 1980 , that (I) (we) lost saw the deceased alive on March 18, 1980 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE
John G. Fawcett | | DEGREE
M.D. | | 22c. DATE SIGNED
4/9/80 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
John G. Fawcett, Md. | | 22e. ADDRESS
16610 Sugarland Road, Boysds, Md. | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
11 April '80 | 23c. NAME OF CEMETERY OR CREMATORY
Arlington Natl. Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Fort Myer, Va. |
| 24. FUNERAL DIRECTOR
NAME
McGuire Funeral Serv. | | 25a. PREPARED BY REG. NO. 1
Washington, D.C. APR 10 1980 | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|---|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | REG. NO. 8010725 | | | | | | |
| 1 DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a DATE OF DEATH MONTH DAY YEAR | | | 2b HOUR |
| Elizabeth C. Leatherman | | | | | | April 21, 1980 | | | 7:50 PM |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH MONTH DAY YEAR | | 6 AGE (IN YEARS LAST BIRTHDAY) | | 7a IF UNDER 1 YEAR MONTHS DAYS | |
| Female | | White | | Oct. 19 1889 | | 90 YRS. | | | |
| 7b BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7c CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | |
| D.C. | | U.S.A. | | | | Montgomery MD. | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY | |
| Wheaton | | Randolph Hills Nursing Home | | | | Clerk | | Engraving & Print. | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 13b COUNTY | | | 13c CITY OR TOWN | | | 13d INSIDE CITY LIMITS? |
| Md. | | | Montgomery | | | Rockville | | | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 14 FATHER'S NAME FIRST MIDDLE LAST | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | |
| James Burns | | | Martha J. Henry | | | No | | | |
| 16b SOCIAL SECURITY NO. | | | 17 INFORMANT | | | ADDRESS | | | |
| 577-05-1567 D | | | Nephew | | | Silver Spring, Md. | | | |
| | | | Dr. James T. Burns | | | 2203 Glenallan Ave | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 410- } DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u> | | | | | | | | 1 1/2 hr | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | 30+ years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Heart Failure</u> | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| | | | P.M. 19 | | | | | | |
| 21d INJURY OCCURRED | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET | | CITY OR TOWN COUNTY STATE | | |
| WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>March</u> 19 <u>80</u> to <u>April 21</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>April 12</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE | | | | | DEGREE | | 22c DATE SIGNED | | |
| Joseph Neill Kennedy, M.D. | | | | | | | 4/21/80 | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e ADDRESS | | | | |
| Joseph Neill Kennedy, M.D. | | | | | 1145 - 19th St. N.W. Washington, D.C. | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION CITY OR TOWN COUNTY STATE | | |
| Burial | | | 4/24/1980 | | Cedar Hill Cemetery | | Suitland, Maryland. | | |
| 24 FUNERAL DIRECTOR NAME | | | | | | 25a DATE REC'D. BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | |
| Joseph Lawler's Sons Inc. | | | | | | APR 28 1980 | | Joseph Neill Kennedy | |
| 5130 Wisc. Ave., N.W. Wash. D.C. | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

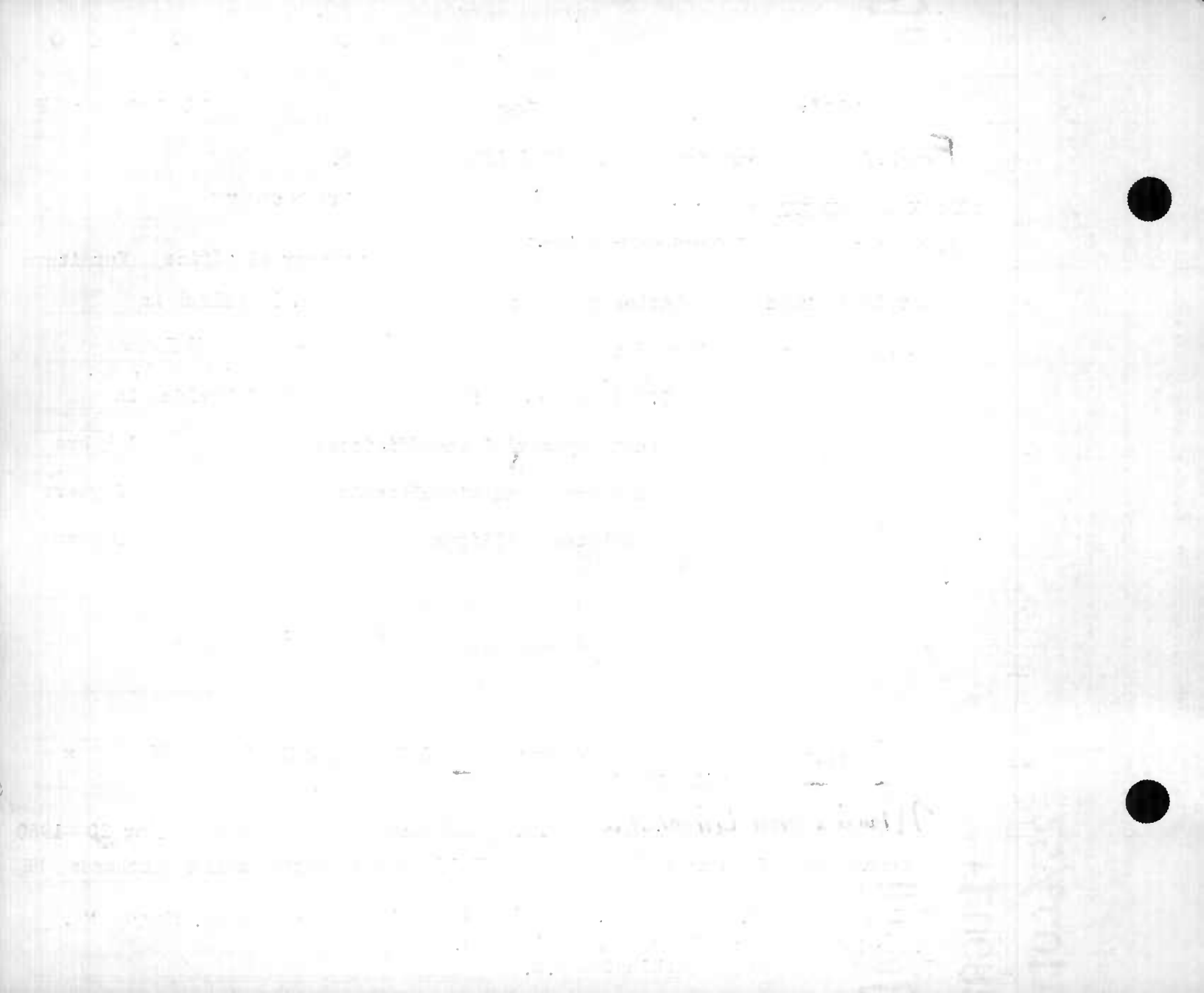
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DEATH RELEASED TO DR. VAN KINSBERG

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | 8 0 1 0 7 2 6 | | | | | | | |
|--|--|--|--|--|---|---|---|--|--|---|--|--|
| 1- FOR STATE REGISTRAR | | | | | REG. NO. | | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT)
Julia C. Lee | | | | | 2a DATE OF DEATH MONTH DAY YEAR
April 20 '80 | | | 2b HOUR
6:35 PM | | | | |
| 3 SEX
Female | | 4 RACE
Caucasian | | 5 DATE OF BIRTH MONTH DAY YEAR
MAR 4 1929 | | 6 AGE (IN YEARS LAST BIRTHDAY)
51 YRS. | | 7 IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS HOURS MIN. | | | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
DISTRICT OF COLUMBIA | | 7b CITIZEN OF WHAT COUNTRY?
U.S. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | | |
| 10 CITY OR TOWN OF DEATH
Bethesda | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOTHING IN FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
manager of office | | 12b KIND OF BUSINESS OR INDUSTRY
furniture | | | | |
| 13a STATE
Maryland | | | | | 13b COUNTY
Mont | | 13c CITY OR TOWN
Bethesda | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST
Roy - Snauffer | | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Florence - McIntyre | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | | | | 16b SOCIAL SECURITY NO.
577401092 | | 17 INFORMANT Husband
J. Howard Lee | | | ADDRESS Bethesda, Md.
6207 Vorlich La | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1: DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) acute myocardial insufficiency
2500
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) coronary arteriosclerosis
(c) diabetes mellitus
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 1/2 hrs
5 years
5 years | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | |
| 21d INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a I certify that (I) (the hospital) attended the deceased from January 19, 1979, to April 20, 1980, that (I) (we) last saw the deceased alive on April 19, 1980, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. | | | | | | | | | | 22c DATE SIGNED
Apr 20 1980 | | |
| 22b SIGNATURE
Maurice van Kinsbergen | | | | | DEGREE
M.D. | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
Maurice van Kinsbergen | | | | | 22e ADDRESS
57 15 Massachusetts Avenue Bethesda Md | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b DATE
Apr. 24 1980 | | 23c NAME OF CEMETERY OR CREMATORY
St. Aloysius Cemetery | | 23d LOCATION
CITY OR TOWN COUNTY STATE
Leonardtown St. Marys Md. | | | | | | |
| 24 FUNERAL DIRECTOR NAME
Robert A. DeVol | | | | | 24b FUNERAL HOME
DeVol Funeral Home | | 24c ADDRESS
2222 Wisc Ave. Washington D.C. | | 25a DATE REC'D. BY REGISTRAR
APR 28 1980 | | 25b REGISTRAR'S SIGNATURE
[Signature] | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 0 1 0 7 2 7
REG. NO.

| | | | | | | | | | | | |
|--|--|-------------------------|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
VERNE C LEWELLEN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
APRIL 16, 1980 | | | 2b. HOUR
0200 AM | | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
9/29/01 | | 6. AGE
(YEARS LAST BIRTHDAY)
78 YRS | | 7. # UNDER 1 YEAR
MONTHS DAYS HOURS MIN
78 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
Nebraska | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | |
| 10. CITY OR TOWN OF DEATH
ROCKVILLE | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SHADY GROVE ADVENTIST HOSPITAL | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Business Mgr. | | | 12b. KIND OF BUSINESS OR INDUSTRY
Green Bay Packers | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
Montgomery | | | 13b. CITY OR TOWN
Gaithersburg | | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13d. STREET ADDRESS
6 Sunnyside Crt. | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph Clark Lewellen | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Ellen Trump | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO
(IF YES, GIVE WAR OR DATES)
388-16-2692 | | |
| 17. INFORMANT
Verne C. Lewellen, Jr. | | | ADDRESS
6 Sunnyside Court Gaithersburg, Md | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Empyema, right
DUE TO, OR AS A CONSEQUENCE OF
(b) Pneumonia, right
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
4-86- | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 1/2 mo
1 3/4 mo | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
Atherosclerotic Heart Disease with Congestive Heart Failure | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 3/12/80 to 4/16/80 , that (I) (we) saw the deceased alive on 4/15/80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Robert C. Macon | | | DEGREE
M.D. | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
4/16/80 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Robert C. Macon | | | 22e. ADDRESS
809 Viers Mill Rd. Rockville, Md. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
Apr. 19, 1980 | | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Howard Cemetery | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Green Bay Brown Wisconsin | | |
| 24. FUNERAL DIRECTOR
NAME
Schauer & Schumacher | | | ADDRESS
340 S. Monroe St. Green Bay Wiscon | | | 25a. DATE REC'D. BY REGISTRAR
APR 21 1980 | | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | |

• 2000



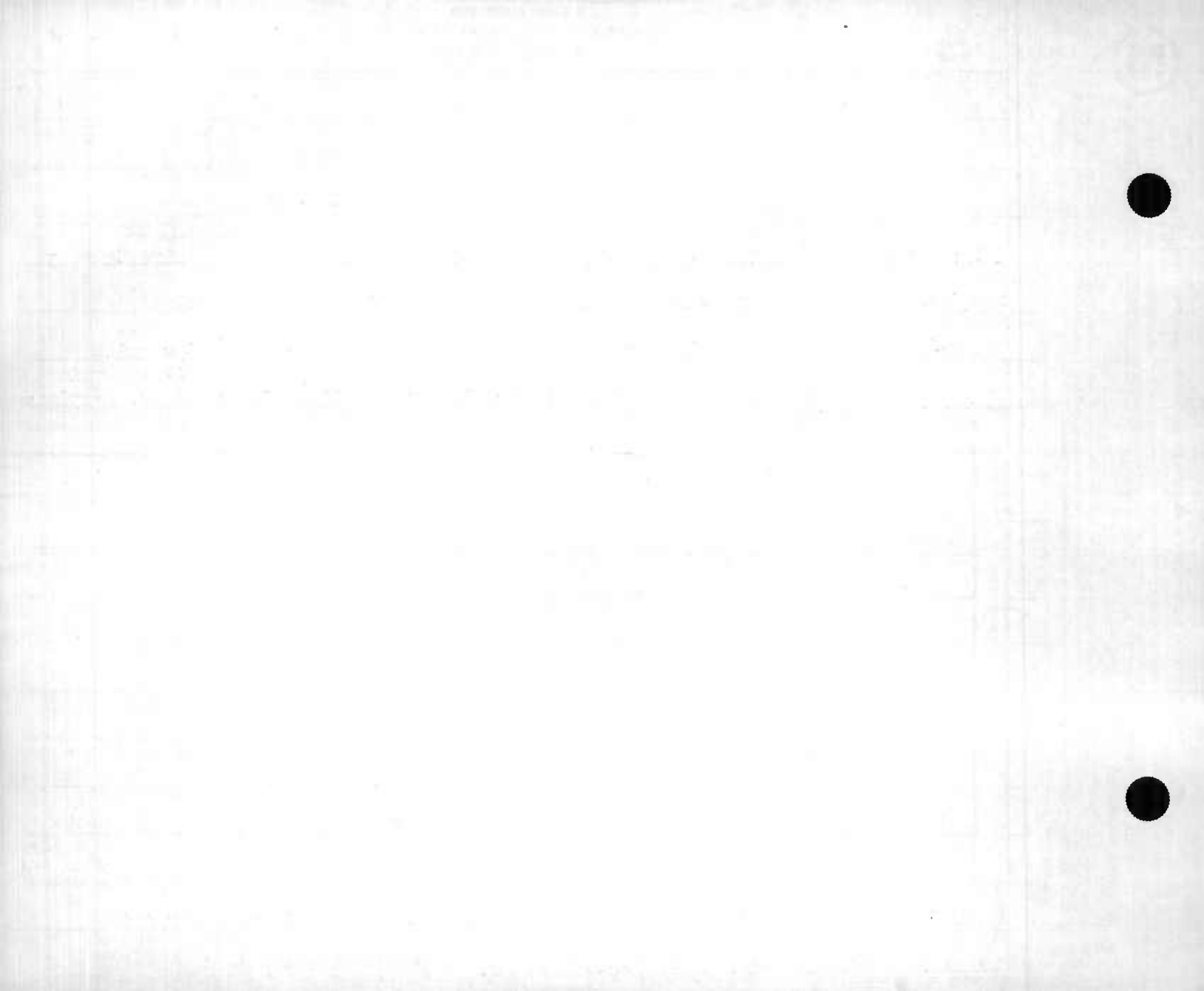
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

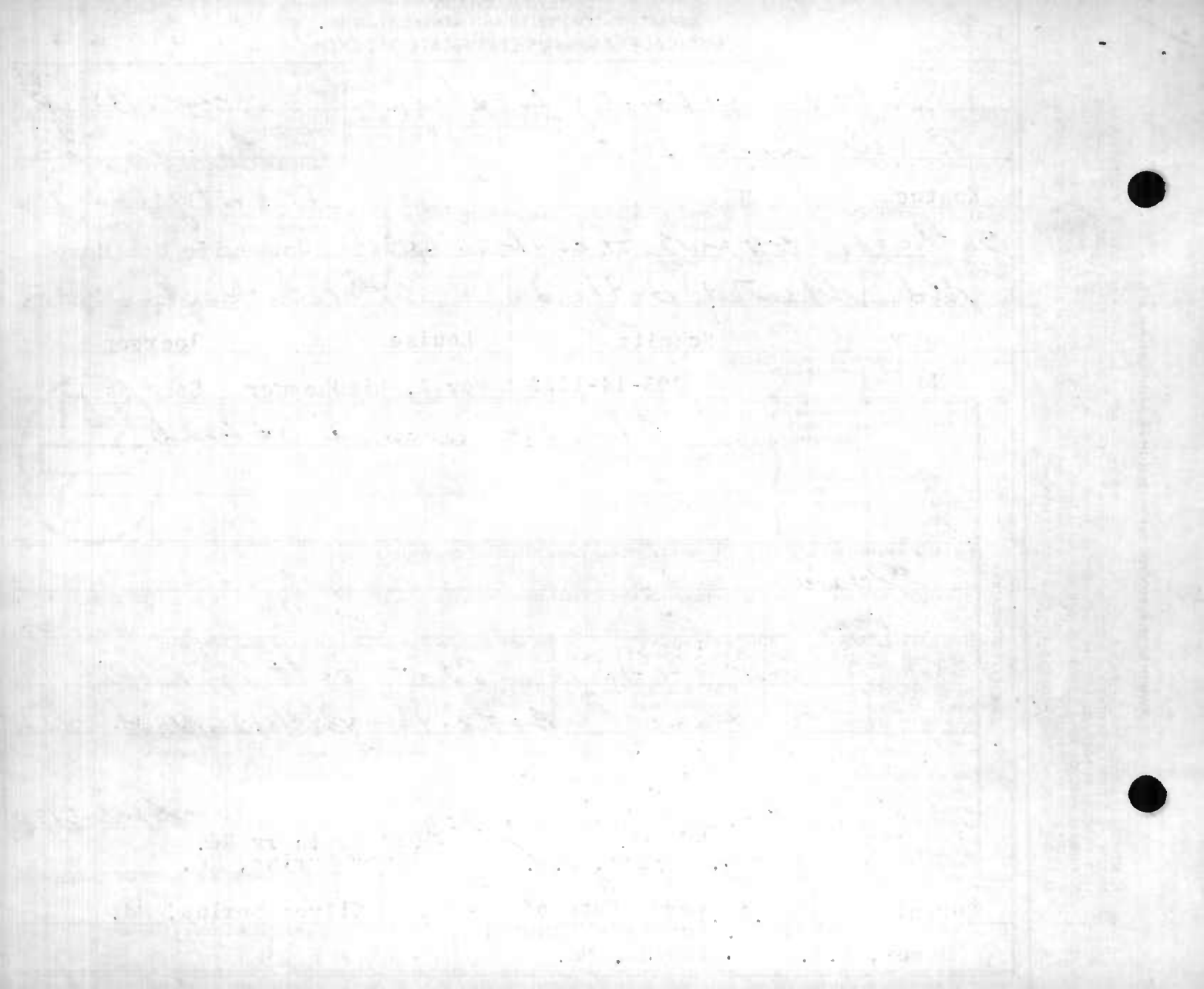
1501 BP

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
<i>Melvin Lieberman</i> | | | | 2a. DATE OF DEATH MONTH DAY YEAR
<i>4/24/80</i> | | | | 2b. HOUR AM PM
<i>3:45 AM</i> | |
| 3. SEX
<i>Male</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH MONTH DAY YEAR
<i>6-23-30</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>49</i> YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Hungary</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery</i> MD. | | | |
| 10. CITY OR TOWN OF DEATH
<i>Takoma Park</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Washington Adventist Hospital</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Sales</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Tire Company</i> | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE <i>Maryland</i> 13b. COUNTY <i>Montgomery</i> 13c. CITY OR TOWN <i>Silver Spring</i> | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
<i>11620 Lockwood Drive</i> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
<i>Joseph --- Lieberman</i> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
<i>Esther --- Berkowitz</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
<i>Yes</i> | | | | 16b. SOCIAL SECURITY NO.
<i>WWII 161-24-6020</i> | | 17. INFORMANT ADDRESS
<i>Silver Spring, Maryland</i>
<i>Helen Lieberman, 11620 Lockwood Dr.</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cancer of the stomach</i>
1519
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>2 years</i> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>GI bleed lower failure</i> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <i>4/10</i> 19 <i>80</i> , to <i>4/24</i> 19 <i>80</i> , that (I) (we) lost the deceased alive on <i>4/23/80</i> 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>Michael R. Poston</i> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
<i>4/24/80</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Michael R. Poston</i> | | | | 22e. ADDRESS
<i>4109 Springs St, Silver Spring, Md</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>4-27-80</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>King David Mem. Gdn.</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE
<i>Falls Church, Virginia</i> | | | |
| 24. FUNERAL DIRECTOR NAME
<i>DANZANSKY-GOLDBERG MEM. CHAP., Rockville, Md.</i> | | | | 25a. DATE REC'D. BY REGISTRAR
<i>APR 29 1980</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Hilary McLeod</i> | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETURN TO THE DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|
| 1- STATE REGISTRAR | | | | | | | | | |
| 2. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST | | | | | | | | | |
| BETTY SCHMITZ LIEDHEGNER | | | | | | | | | |
| 3. SEX 4. RACE 5. DATE OF BIRTH MONTH DAY YEAR 6. AGE (LAST BIRTHDAY) 7. IF UNDER 1 YR. 8. IF OVER 24 HRS. 9. DATE OF DEATH KNOWN OF EST. MATED 10. DATE PRONOUNCED DEAD | | | | | | | | | |
| F W Apr 29 22 57 YRS. MONTHS DAYS HRS. MIN. April 23 1980 | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) 7b. CITIZEN OF WHAT COUNTRY? 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | |
| Kentucky USA Montgomery MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| Bethesda 4970 Battery Lane Apt 501 Housewife Home | | | | | | | | | |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS | | | | | | | | | |
| Md. Montgomery Bethesda YES NO 4970 Battery Lane Apt 501 | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | | | |
| Henry Schmitz Louise Joerger | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) 16b. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS | | | | | | | | | |
| No 293-14-1225 Roy A. Liedhegner Same as 13 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9554 Gunshot wound of head. | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| None | | | | | | | | | |
| 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| None | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | |
| 1100 4-14-80 Shot self in mouth | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| Home Bethesda Montgomery Md. | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE TITLE (SPECIFY) MEDICAL EXAMINER DATE SIGNED | | | | | | | | | |
| John S. Rogers, M.D. Dep 1919 Seminary Rd. April 23 1980 | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) ADDRESS | | | | | | | | | |
| John S. Rogers, M.D. Silver Spring, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) 23b. DATE 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | |
| Burial Apr. 26, 1980 Gate of Heaven Silver Spring, Md. | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Md. APR 29 1980 Patrick McCready | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8010730 | | | |
|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) <u>Artoine, the S. LOCK</u> | | | | 2a. DATE OF DEATH MONTH DAY YEAR <u>APR 29 '80</u> | | 2b. HOUR <u>7:15</u> PM | |
| 3. SEX <u>Female</u> | | 4. RACE <u>White</u> | | 5. DATE OF BIRTH MONTH DAY YEAR <u>1 11 1901</u> | | 6. AGE IN YEARS (LAST BIRTHDAY) <u>79</u> YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Illinois</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> MD. | |
| 10. CITY OR TOWN OF DEATH <u>Rockville</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Collingswood Nursing Home</u> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u> | | 12b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | |
| 13a. STATE <u>Maryland</u> | | 13b. COUNTY <u>Montgomery</u> | | 13c. CITY OR TOWN <u>Rockville</u> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <u>Daniel Gouveia</u> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Sadie Fernandes</u> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>no</u> | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>---</u> | | 17. INFORMANT ADDRESS <u>348 24 9561</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>1749 METASTATIC CARCINOMA</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma, Breast</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>2 years</u> | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <u>---</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) <u>this hospital</u> attended the deceased from <u>NOV 79</u> to <u>4/29 80</u> , that (1) <u>we</u> last saw the deceased alive on <u>4/27 80</u> , and that in (my) <u>last</u> opinion death occurred on the date and hour and from the causes stated above. (I <u>did not</u> view the body after death.) | | | | | | | |
| 22b. SIGNATURE <u>Thos. G. Ward</u> DEGREE <u>M.D.</u> | | | | 22c. DATE SIGNED <u>4/30/80</u> | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Thos. G. Ward</u> | |
| 22e. ADDRESS <u>6116 Robinwood, Bethesda, Md 20034</u> | | | | 22f. DATE REC'D. BY REGISTRAR <u>MAY 5 1980</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b. DATE <u>5/5/80</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Oakridge Cemetery</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Springfield, Illinois</u> | |
| 24. FUNERAL DIRECTOR NAME <u>Tyson Wheeler Funeral Home, Inc.</u> | | | | 25. DATE REC'D. BY REGISTRAR <u>MAY 5 1980</u> | | | |
| 1331 Rockville Pike Rockville, Maryland | | | | | | | |

500

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. The deceased remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to (a) cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|---|--|------------------------------------|--|---|--|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) | | | 2a DATE OF DEATH | | | MONTH DAY YEAR | | 2b HOUR | |
| FIRST MIDDLE LAST
Retta B. Luddeke | | | Apr. 14 80 | | 1 P.M. | | | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | |
| female | | white | | MONTH DAY YEAR
Sept. 2, 1899 | | 80 YRS | | MONTHS DAYS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Penna. | | U. S. A. | | | | Montgomery MD | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY | |
| Rockville | | The Hebrew Home for the Aged | | | | Housewife | | own home | |
| 13a STATE | | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? | | |
| Maryland | | | Montgomery | | Rockville | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14 FATHER'S NAME | | | 15 MOTHER'S MAIDEN NAME | | | 13e STREET ADDRESS | | | |
| FIRST MIDDLE LAST
William Berkowitz | | | FIRST MIDDLE LAST
Sarah Kimmelman | | | 6121 Montrose Road | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b SOCIAL SECURITY NO | | | 17 INFORMANT | | | |
| no | | | ---- | | | 7836 Godolphin Drive
Springfield, Virginia | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) SEPTICEMIA | | | | | | | | | 1 WEEK |
| 7 4820 DUE TO, OR AS A CONSEQUENCE OF (b) URINARY INFECTION; PRESSURE ULCER | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) KLER. PNEUMONIA | | | | | | | | | |
| SEVERE SENILE DEMENTIA | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| — | | | — | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| | | | HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | | | STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/18/19 78 to 4/14/19 80, that (I) (we) lost saw the deceased alive on 4/14/19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL STAFF <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | |
| D.D. PATEL | | | MD | | | PHYSICIAN <input type="checkbox"/> | | 4/14/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | | | | |
| | | | 621 MONTROSE RD. ROCKVILLE, MD. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | |
| Cremation | | | 4-15-80 | | Cedar Hill Crematory | | Suitland, Prince Georges, Md. | | |
| 24. FUNERAL DIRECTOR NAME | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Joseph Gawler's Sons, Inc. | | | 20016 | | | APR 18 1980 | | | |
| 5130 Wisconsin Ave., N. W., Wash., D. C. | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|--|--|--|--|---|--|---|--|-----------------------------------|--|
| 1. FOR STATE REGISTRAR | | | | | 8 0 1 0 7 3 2 | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | |
| FIRST MIDDLE LAST
William G. Lundberg | | | | | MONTH DAY YEAR HOUR
April 12, 1980 11:30 P.M. | | | | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | |
| Male | | White | | MONTH DAY YEAR
Nov. 7, 1915 | | 64 | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Pa. | | U.S.A. | | | | Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Silver Spring | | Holy Cross Hospital | | | | Salesman | | Furniture Co. | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN
Md. P.G. Hyattsville, | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 5891 36th Ave. | | |
| 14. FATHER'S NAME (FIRST MIDDLE LAST)
George A. Lundberg | | | | | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)
Ethel B. Brown | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Yes WW 2 | | | | | 16b. SOCIAL SECURITY NO.
193-10-1558 | | 17. INFORMANT ADDRESS
Maria G. Lundberg Same as # 13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiomyopathy</u>
4140 } DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Alcoholism</u>
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>March</u>
<u>Year</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>Infector. Bacteremia</u> | | | | | | | | | |
| 19a. DATE OF OPERATION
<u>None</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/8</u> , 19 <u>80</u> , to <u>4/11</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>4/11</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>J. Schuman</u> | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>4/15</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>J. Schuman</u> | | | | | 22e. ADDRESS
<u>9410 Old Georgetown Rd.</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
4/16/80 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Ft. Meyer Arlington Va. | | | |
| 24. FUNERAL DIRECTOR
Francis Gasch's Sons Funeral Home, P.A.
Hyattsville, Maryland | | | | | 25a. DATE REC'D. BY REGISTRAR
APR 17 1980 | | 25b. REGISTRAR'S SIGNATURE
<u>H. McCreedy</u> | | |

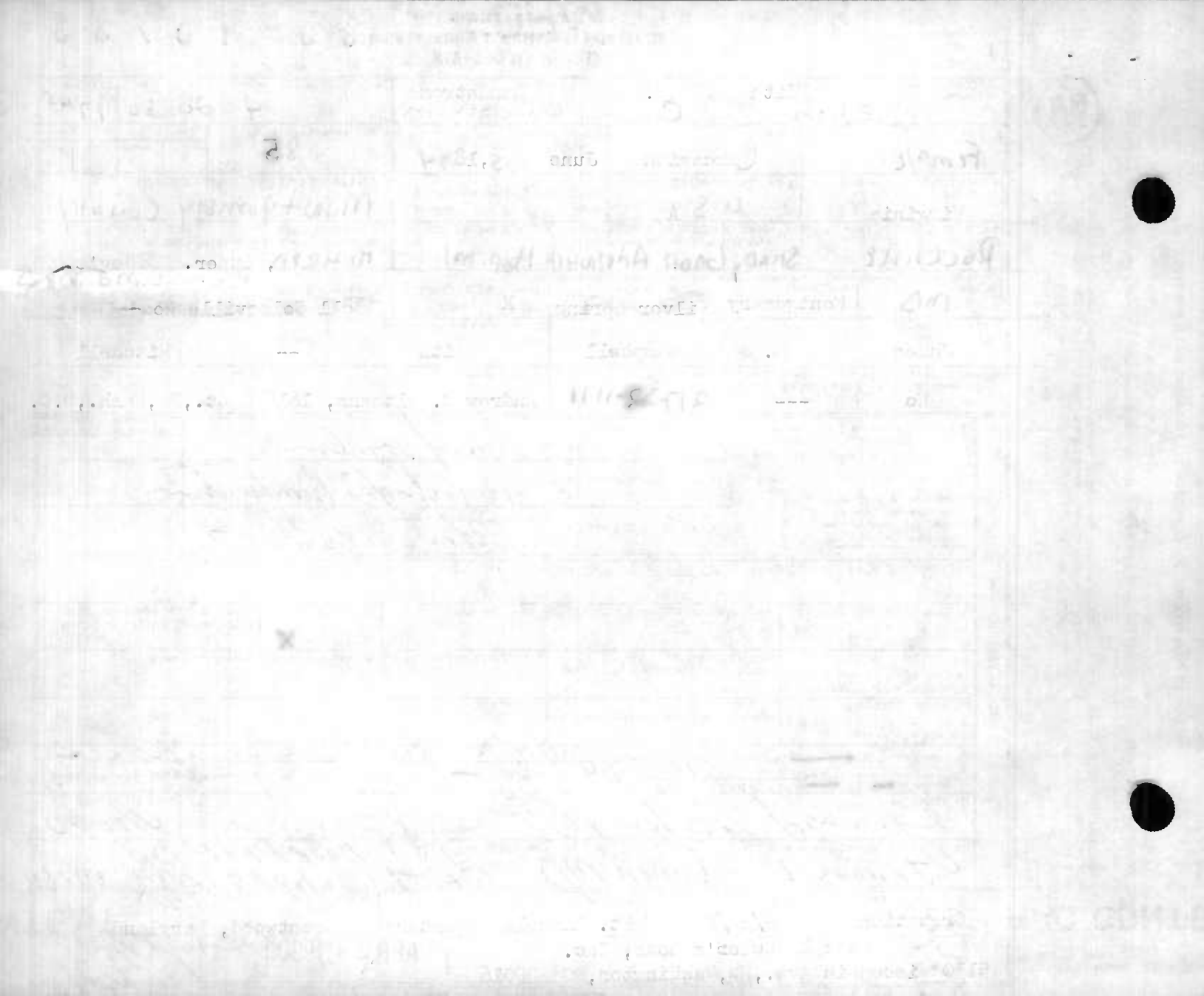
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 0 1 0 7 3 3 | | | |
|---|--|---|--|---|--|---|--|
| 1 - STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST Edith MIDDLE C. LAST Lundstrom | | 2a. DATE OF DEATH | | MONTH DAY YEAR | |
| Edith | | C. Lundstrom | | 4 20 80 | | 2b. HOUR 17 45 M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Female | | Caucasian | | MONTH DAY YEAR
June 5, 1894 | | 85 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Virginia | | U.S.A. | | | | Montgomery County MD | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Rockville | | Shady Grove Adventist Hosp. Md | | Retired Super | | US Gov't | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| MD | | Montgomery | | Silver Spring | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 13e. STREET ADDRESS | | | |
| FIRST MIDDLE LAST
James H. C. Campbell | | FIRST MIDDLE LAST
Edith -- Mitchell | | 18811 Colesville Road, Hunt | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| No | | 217-32-1111 | | Andrew T. Altmann, 1616 H St., NW, Wash., D.C. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 410-
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
(b) myocardial infarction
(c) atherosclerosis | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from
saw the deceased alive on 4/20 19 80 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE
James L. Hooper MD | | DEGREE
MD | | 22c. DATE SIGNED
4/20/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | |
| James L. Hooper MD | | 1st E. Deer Park Dr.
Gaithersburg, MD 20878 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| Cremation | | 4/22/80 | | Ft. Lincoln Crematory | | Brentwood, Maryland | |
| 24. FUNERAL DIRECTOR NAME
Joseph Gawlet's Sons, Inc. | | | | 25a. DATE RECD. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| 5130 Wisconsin Ave., NW, Washington, DC 20016 | | | | APR 24 1980 | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 10734 | |
|---|--|-------------|---|---|--|--|--|----------------------------|--------------------------------------|--|--|
| 1- STATE REGISTRAR | | | | | | | | | | 20. DATE KNOWN OF DEATH | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Paul S. Lyddane | | | | | | | | | | ESTIMATED MONTH DAY YEAR HOUR
4 28 1980 4:30 PM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| male | | cauc | | 4 21 40 | | 40 YRS. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Wash. D.C. | | | USA | | | | | | Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Bethesda | | | Suburban Hospital | | | Accountant | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | | |
| Md. | | Mont. | | Rockville | | | | 12630 Viers Mill Rd. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | |
| Francis H. Lyddane | | | | | | Anna Belle Harkins | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | |
| No | | | | 579 68 5555 | | 1208 S. Thomas St. Arl. Va.
E. Stuart Lyddane (Brother) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Multiple Injuries Severe</u>
9570
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) <u>Trauma from fall - 90 Feet -</u>
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| | | | | 4:00 P.M. 4 28 1980 | | Jumped from Apartment 9th floor. | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | Apartment | | 12630 Viers Mill Rd. Rockville. Mont. Md. | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | |
| John G. Ball | | | | M.D. Deputy | | | | APR 29 1980 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | |
| John G. Ball | | | | 7936 Old Georgetown Rd. Beth. Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | 5/2/80 | | Mt. Olivet Cemetery | | Wash. D.C. | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Hines/Rinaldi F.H. 11800 N.H. Ave. S.S. Md. | | | | MAY 1 1980 | | | | [Signature] | | | |

TO: SAC, [REDACTED] (100-458741)

FROM: SAC, NEW YORK (100-100000) (P)

SUBJECT: [REDACTED]

RE: [REDACTED]

DATE: 5/1/68

BY: [REDACTED]

CLASS: [REDACTED]

FILE: [REDACTED]

NOTES: [REDACTED]

ADMINISTRATIVE: [REDACTED]

DISPOSITION: [REDACTED]

REMARKS: [REDACTED]

APPROVAL: [REDACTED]

SPECIAL AGENT IN CHARGE

NEW YORK OFFICE

TELEPHONE: [REDACTED]

TELETYPE: [REDACTED]

FAX: [REDACTED]

MAIL ROOM: [REDACTED]

RECEIVED: [REDACTED]

DATE: 5/1/68

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic agent, the medical examiner must be notified at once.

Classified with medical examiner

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | |
|--|--|--|---|---|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | 8 0 1 0 7 3 5
REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
Lottie Lillian Magers | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
April 9 1980 | | | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
Jan 27 1893 | | 6. AGE (IN YEARS LAST BIRTHDAY)
87 YRS | | 2b. HOUR
11:04 P.M. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Adventist Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
clerk | | 12b. KIND OF BUSINESS OR INDUSTRY
Retail store | | |
| 13a. STATE
md | | | 13b. COUNTY
mnt | | 13c. CITY OR TOWN
Germantown | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
P.O. Box 88 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Thomas Berry | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE
Ella Ricketts | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | | | 16b. SOCIAL SECURITY NO
not available | | 17. INFORMANT ADDRESS
Wm Magers (son) German town, md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 410- Acute myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF (c) 10 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
15 hours | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Congestive heart failure | | | | | | | | | | |
| 19a. DATE OF OPERATION
None | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)
None | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 16, 1967, to April 9, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Stephen C. Cromwell | | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
4-9-80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Stephen C. Cromwell, M.D. | | | | | 22e. ADDRESS
615 W. Montgomery Rockville, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
4-12-80 | | 23c. NAME OF CEMETERY OR CREMATORY
Darnestown Cemetery | | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Darnestown Montg. Maryland | | |
| 24. FUNERAL DIRECTOR NAME
Robert A. Pumphrey | | | | | FUNERAL HOMES P/A
300 W. Montgomery Ave., Rockville, Md. | | | 25. DATE REC'D BY REGISTRAR
APR 16 1980 | | |

Handwritten vertical text on the right margin, possibly a date or reference number.

Robert A. Murphy Funeral Home, Inc.
300 W. Montgomery Ave., Rockville, Md.
4-15-60 (Jameson Cemetery) Maryland, Maryland

Stephen C. Crowell, M.D. 618 W. Montgomery Rockville, Md.

April 9 to April 10 1960

Computer text files

Outstanding information

not available W. Rogers (and) German Town, Md.

Thomas Barry Ella

Rockville, Md. 20854 USA

Lottie Lillian Rogers

April 11 1960



DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))
15M 7/77

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 10736 | |
|---|--|-------------------------|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Walfred V Maki | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED
MONTH DAY YEAR
4-10-1980 | | 2b. HOUR
PM
6:35 | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
12-9-24 | | 6. AGE (IN YEARS)
LAST BIRTHDAY
55 YRS. | | IF UNDER 1 YR.
MONTHS DAYS
0 0 | | IF UNDER 24 HRS.
HOURS MIN.
0 0 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Minn. | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Lawyer | | | 12b. KIND OF BUSINESS OR INDUSTRY
Title Attr. | | |
| 13a. STATE
--- | | | | 13b. COUNTY
--- | | 13c. CITY OR TOWN
Washington, DC | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
5331 Belt Road, N.W. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Edward --- Maki | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
(Unknown) | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
Yes | | | | 16b. SOCIAL SECURITY NO.
WW II | | 17. INFORMANT
ADDRESS
Patricia M. Maki, Wife, Same as # 13. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Insufficiency Acute.
DUE TO, OR AS A CONSEQUENCE OF
(b) Arterio-Sclerotic Cardio-Vascular Disease.
DUE TO, OR AS A CONSEQUENCE OF
(c) ---
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
GKA Brain Aneurysm. | | | | | | | | | | | |
| 19a. DATE OF OPERATION
--- | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
--- | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
--- | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
--- | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
--- | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE
John G. Ball | | | | TITLE (SPECIFY)
Deputy | | | | DATE SIGNED
April-14-1980 | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
John G. Ball | | | | ADDRESS
Bethesda, Montgomery Co., Maryland | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
4/14/80 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cem. | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Silver Spring, Maryland | | | |
| 24. FUNERAL DIRECTOR
Joseph Gawler's Sons, Inc. | | | | | | 25a. DATE REC'D. BY REGISTRAR
APR 16 1980 | | 25b. REGISTRAR'S SIGNATURE
--- | | | |
| 5130 Wisconsin Ave., NW, Washington, D.C. 20016 | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

DHMH-16 25M
(VRA 15, 4) 1/79

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8010737 | | | |
|---|--|--|---|---|------------------------------------|--|--|---|---|-----------------------------|---------------|--|--|
| FOR
STATE
REGISTRAR | | | REG. NO. | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | 2b. HOUR | | | | |
| Conrad B. Mang | | | | | | 04 27 80 | | | 108 PM | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. | | | IF UNDER 1 YEAR MONTHS DAYS | | | |
| Male | | White | | 04 05 1900 | | | 80 | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH MD. | | | | | | |
| Wash., D.C. | | U.S. | | | | | MONT. COUNTY | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Silver Spring | | Holy Cross Hospital | | | | Ret. U.S. Gov't. | | | - | | | | |
| 13a. STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | | | |
| MD | | | P.G. | | ADELPHI | | YES | | 10515 Edgfield St. | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | | | | |
| Bernhardt Mang | | | (Unknown) | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | ADDRESS | | | Same as Above | | |
| No | | | 579-38-8737A | | Teresa C. Mang (Wife) | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a).
410 - Acute Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF (b).
Arteriosclerotic heart disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }
DUE TO, OR AS A CONSEQUENCE OF (c).
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 days
Years | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11(a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 1976 to 4/27 1980, that (I) (we) first saw the deceased alive on 4/27 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
C. J. Fennell, M.D. | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
4/27/80 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e. ADDRESS | | | | | | | |
| | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | | 5-1-1980 | | Ft. Lincoln Cem. | | | Brentwood Pr. Geo. Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | | | 25a. MAY 5 1980 BY REGISTRAR | | | 25b. DECEASED'S SIGNATURE | | | | |
| Nalley's F.H. Inc. Mt. Rainier, Md. | | | | | | | | | | | | | |

100-67

275



Wash., D.C.

Set on Sunday

Ref. U.S. Court

(Institution)

77-38-8737A

State Department

Internal Security - Matter

100-67

100-67

100-67

100-67

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

80 10 / 38

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|---|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) JACK | | FIRST MARKEL | | LAST | | 2a. DATE OF DEATH
MONTH April DAY 12 YEAR 1980 | | 2b. HOUR
4:16 M | |
| 3. SEX
Male | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH Oct DAY 19 YEAR 1897 | | 6. AGE (IN YEARS LAST BIRTHDAY)
82 YRS | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 HOURS 0 MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SALESMAN | | 12b. KIND OF BUSINESS OR INDUSTRY
CLOTHING | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD. 13b. COUNTY Montgomery 13c. CITY OR TOWN Silver Spring | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
8103 Eastern Ave. | | |
| 14. FATHER'S NAME
SAMUEL MIDDLE MARKEL | | | | | 15. MOTHER'S MAIDEN NAME
RACHEL MIDDLE CAPLIN | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO
212 12 7855 | | 17. INFORMANT
ADDRESS 12810 SUTTERS LANE, BOWIE, MARYLAND | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio-pulmonary arrest
1539
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 45 min. | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) post-op. wound dehiscence | | | | | | | | | |
| 19a. DATE OF OPERATION
3-31-80 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Carcinoma right colon
clavicle & wound dehiscence | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET
CITY OR TOWN
COUNTY
STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-31 , 19 80 , to 4-12 , 19 80 , that (I) (we) lost
saw the deceased alive on 4-11 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Ira N. Brecher | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
4-12-80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
IRA N. BRECHER, MD | | | | 22e. ADDRESS
8630 Cameron CT
Silver Spring, MD 20910 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
4/14/1980 | | 23c. NAME OF CEMETERY OR CREMATORY
B'NAI ISRAEL CEMETERY | | 23d. LOCATION
BALTIMORE BALTIMORE MD. | | | |
| 24. FUNERAL DIRECTOR
DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME
232 CARROLL STREET, N. W., WASHINGTON, D. C. | | | | 25. DATE REC'D. BY REGISTRAR
APR 16 1980 | | 25b. REGISTRAR'S SIGNATURE
Jeffrey McCreedy | | | |

WATER

1-11

CHURCH

1-11

CHURCH

CHURCH

CHURCH

NO

CHURCH

CHURCH

CHURCH

CHURCH

CHURCH

CHURCH

CHURCH

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| Part 2 0342 4/29/80 Dad | | | | | | | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 10739 | | | | | | | | | |
|--|--|------------------|--|--|--|---|--|---|--|--|--|--|--|---|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Agnes K. Marshall | | | | | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
4 3 19 80 | | | | | | | | | | 2b. HOUR
M
9:55 P M | | | | | | | | | | | | | | | | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Mar. 30, 1913 | | 6. AGE (IN YEARS)
LAST BIRTHDAY
67 YRS. | | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
4 3 19 80 | | 2d. HOUR
M
9:55 P M | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
5225 Pooks Hill Road | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. STATE
Md. | | | | | | | | | | 13b. COUNTY
Montg. | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
5225 Pooks Hill Rd. | | | | | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Kiely | | | | | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Elizabeth Bryson | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
129-10-0968 | | | | 17. INFORMANT
ADDRESS
2016 N. Adams St. Arlington, Va. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease
4292
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
Diabetes mellitus | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | | | | | | 21f. LOCATION
CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
Virginia L. Dolan | | | | | | | | | | TITLE (SPECIFY)
Assistant | | | | | | | | | | DATE SIGNED
4/4/80 | | | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
Virginia L. Dolan, M.D. | | | | | | | | | | ADDRESS
111 Penn Street | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | | | | | | | 23b. DATE
Apr. 8, 1980 | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Cross Cem. | | | | | | | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brooklyn, New York | | | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Homes, P.A. | | | | | | | | | | ADDRESS
Bethesda, Md. | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR
APR 9 1980 | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE
L. J. [Signature] | | | | | | | | | |

ST. 207.912

NEW YORK

RECEIVED

APR 14

1941

1941

145-10-0208

RECEIVED

1941

RECEIVED

APR 14 1941

APR 14 1941

APR 14 1941

APR 14 1941

RECEIVED

sc1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 0 1 0 7 4 0 | | | |
|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | |
| Jack Leonard Marquis | | | | April 27, 1980 | | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | |
| Male | | White | | February 11, 1920 | | 60 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | |
| Ohio | | U.S.A. | | | | Montgomery County MD | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Bethesda | | Clinical Center, Bethesda, MD | | Tool Engineer | | Chrysler Corp | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d. INSIDE CITY LIMITS? | | | |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| Ohio Montgomery Protwood | | | | 13e. STREET ADDRESS | | | |
| | | | | 314 Grand Ave. 45426 | | | |
| 14 FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | |
| 14a. FIRST 14b. MIDDLE 14c. LAST | | | | 15a. FIRST 15b. MIDDLE 15c. LAST | | | |
| Ralph L. Marquis | | | | Jessie Ellen Schardt | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17 INFORMANT | |
| Yes WWII | | | | 274-18-6900 | | Mrs. Harriet Marquis (same as above) | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I DEATH WAS CAUSED BY | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> | | | | | | | |
| 2849 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| (b) <u>Hypoplastic Anemia</u> | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (c) <u>Fever of Unknown Etiology</u> | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>March 31, 1980</u> , to <u>April 27, 1980</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>April 27, 1980</u> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (we) did not view the body after death. | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | 22c. DATE SIGNED | |
| <u>Frank L. Douglas</u> | | | | MD | | 4/27/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |
| <u>Frank L. Douglas</u> | | | | <u>National Institutes of Health
Clinical Center, Bethesda, MD 20205</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| Burial | | May 1, 1980 | | Memorial Park | | Dayton Ohio | |
| 24 FUNERAL DIRECTOR
NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| <u>ROBERT A. PUMPHREY
P.A., BETHESDA, MARYLAND</u> | | | | MAY 1 1980 | | <u>Robert A. Pumphrey</u> | |

CONFIDENTIAL

100-100000

Good Engineer, Chrysler Corp.

Montgomery

Salmon, L. J. Dennis, Jessica, Ellen, Escherich

Yes, Will

100-100000

X

Robert A. Roubert
Theodore, Hayward

Robert A. Roubert
Theodore, Hayward

Dayton

Ohio

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8010741 | | | |
|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
IDA MAE MASTIN | | | | 2a. DATE OF DEATH MONTH DAY YEAR
APR 27 80 | | 2b. HOUR
10:30P | |
| 3 SEX
FEMALE | | 4 RACE
WHITE | | 5 DATE OF BIRTH MONTH DAY YEAR
Nov. 9, 1890 | | 6 AGE (IN YEARS LAST BIRTHDAY)
89 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Wash. D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10 CITY OR TOWN OF DEATH
Fairland | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Fairland Nursing Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
Red Cross | |
| 13a. STATE
Md. | | | | 13b. CITY OR TOWN
Charles | | 13c. STREET ADDRESS
Rt. #1 Box 435 | |
| 14 FATHER'S NAME FIRST MIDDLE LAST
Joshua C. Mastin | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Ida Mathilde | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)
None | | 17 INFORMANT ADDRESS
228-40-9868 Doris M. Torreyson same as #13 | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) 436- CEREBROVASCULAR ACCIDENT
DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROSIS
DUE TO, OR AS A CONSEQUENCE OF (c) SENILITY
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 WEEKS
4 YEARS
4 YEARS | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from June 1975 to APR 27 80, that (I) (we) last saw the deceased alive on 4/25 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Thos G. Ward M.D. | | | | 22c. DATE SIGNED
4/28/80 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Thos G. WARD, 6116 ROBIN WOOD, BETHESDA, MD 20814 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
4/30/80 | | 23c. NAME OF CEMETERY OR CREMATORY
Rock Creek Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington D.C. | |
| 24 FUNERAL DIRECTOR
NAME Lee Funeral Home Inc. | | | | 25a. DATE RECEIVED BY REGISTRAR
MAY 2 1980 | | 25b. REGISTERING SIGNATURE
Betsy McCrady | |
| 6633 Old Alexander Ferry Road Clinton, Md. | | | | | | | |

10-11-1950

Mr. J. H. [illegible]

Nov. 1, 1950

Received of [illegible]

for [illegible]

the sum of [illegible]

Five hundred and no/100

Dollars

for [illegible]

and no/100

Dollars

for [illegible]

and no/100

Dollars

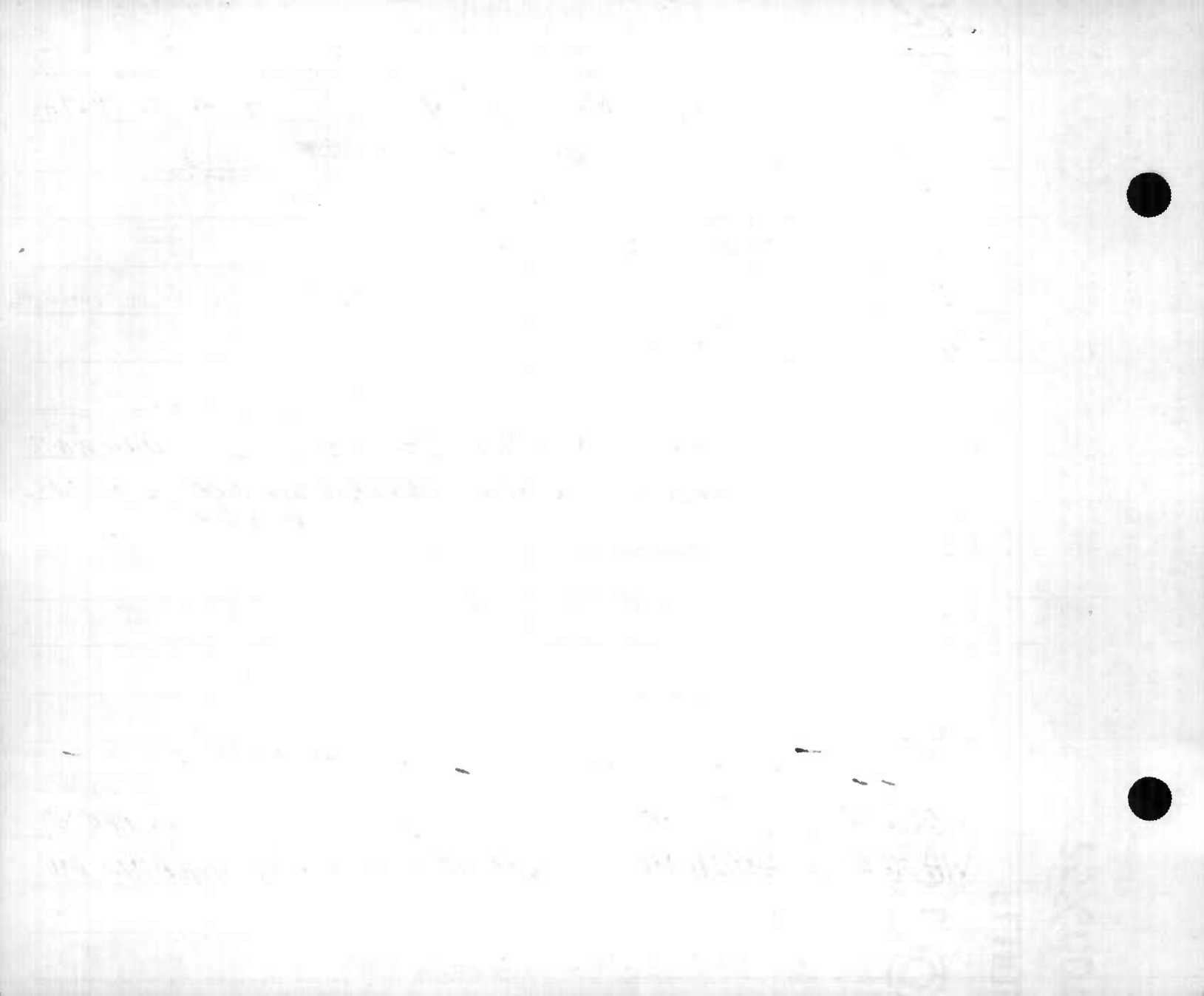
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 0 1 0 / 4 2 | | | |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
MARIE K MATHIESON | | | | 2a. DATE OF DEATH MONTH DAY YEAR
4 26 80 | | 2b. HOUR
7:27 AM | |
| 3. SEX
Female | | 4. RACE
CAUC | | 5. DATE OF BIRTH MONTH DAY YEAR
Jan. 8 1885 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN
95 3 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Arkansas | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Collingswood 299 Hurley AVE | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
retired | | 12b. KIND OF BUSINESS OR INDUSTRY
RFC | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. CITY OR TOWN
VA. Arlington | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1701 S. Pollard St. Arlington, VA | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
William Kimmons | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Dora Lipe | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO
228-40-9331 | | 17. INFORMANT ADDRESS
Anita Elliot 1701 S. Pollard St. Arlington, VA | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIO RESPIRATORY FAILURE
4370
DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO SCLEROTIC CEREBRO VASCULAR DISEASE
DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE
6 YEARS | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19
20 APR 80 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) did not attended the deceased from 19 74 to 26 APRIL 19 80 , that (I) was lost saw the deceased alive on 20 APR 19 80 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) did not (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Walter E. Goode MD | | | | DEGREE
MD | | 22c. DATE SIGNED
26 APR 80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
WALTER E. GOODE MD | | | | 22e. ADDRESS
2309 SHOREFIELD ROAD WHEATON MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
4/29/80 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Washington, D.C. | |
| 24. FUNERAL DIRECTOR NAME
Murphy Funeral Home | | | | 25a. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
MAY 1 1980 | | | |
| ADDRESS
4510 Wilson Blvd. Arlington, VA | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

1- FOR STATE REGISTRAR

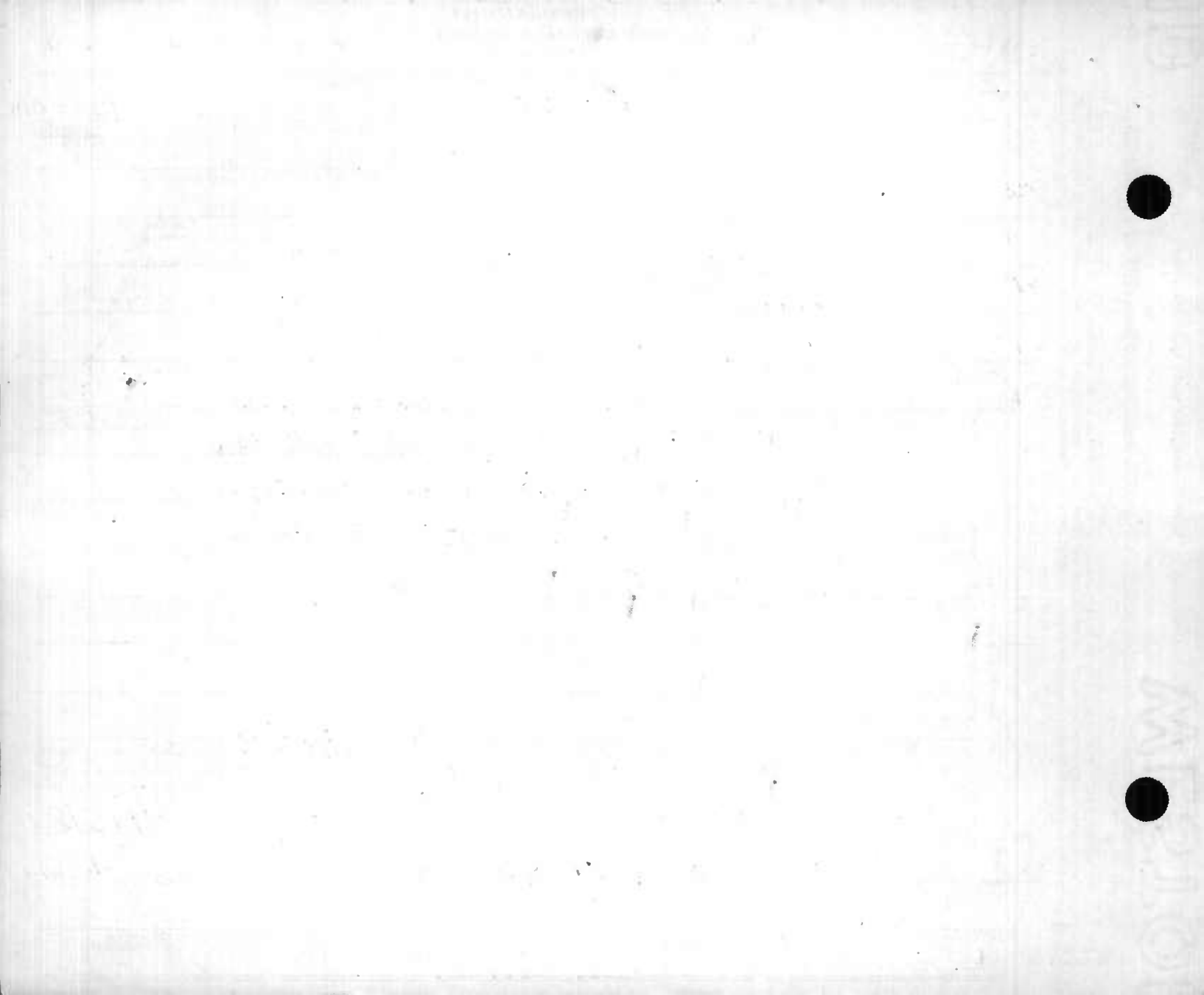
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 1 0 7 4 3

REG. NO.

| | | | | | | | | |
|---|--|--|--|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Arthur R. MAUPIN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
4 15 80 | | | 2b. HOUR
12:05 AM | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
5 12 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY)
77 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Potomac Valley Nursing Home | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
U.S. Government | | |
| 12b. KIND OF BUSINESS OR INDUSTRY
Retired | | | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | | 13b. COUNTY
AA | | 13c. CITY OR TOWN
Annapolis | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Arthur C. Maupin | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ada | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
052-18-4850A | | 17. INFORMANT
ADDRESS
1547 Bruton Ct. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Cerebral Vascular Accident
436-
DUE TO, OR AS A CONSEQUENCE OF
(b) Generalized Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c) AND Parkinson's Disease | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
CORONARY ARTERY DISEASE | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from MARCH 23 19 79, to APRIL 15 19 80, that (I) (we) (lost) saw the deceased alive on APRIL 14 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
R.C. Daddario MD | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
4/15/80 | | |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT)
ROBERT C. DADDARIO | | 23b. ADDRESS
5413 CEDAR LANE BETHESDA | | | | | | |
| 23c. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23d. DATE
4/18/80 | | 23e. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23f. LOCATION
CITY OR TOWN COUNTY STATE
Suitland, Maryland | | |
| 24. FUNERAL DIRECTOR
NAME
Warner E. Pumphrey, Inc. | | ADDRESS
8434 Ga. Ave.
Sil. Spr., Md. | | 25a. DATE REC'D. BY REGISTRAR
APR 21 1980 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | |

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMM-17
(VR A15 ME (1))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

10744

| | | | | | | | | | | | |
|---|---------|--|--------|--|---|---|--|--|----------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE KNOWN
OF DEATH | | ESTI-
MATED | MONTH | DAY | YEAR | 2b. HOUR
a.m. |
| MARY Ellen McCABE | | | | | 4 | | | 21 | | 1980 | 10:44 |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH
MONTH DAY YEAR | | 6. AGE (IN YEARS)
LAST BIRTHDAY | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | | 2c. DATE
PRONOUNCED
DEAD | | MONTH DAY YEAR | | 2d. HOUR
a.m. |
| Female | WHITE | 8 16 08 | | 71 YRS. | | | April 21 | | 1980 | | 10:44 |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| Minnesota | | U.S.A. | | | | | Montgomery County MD. | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS
OR INDUSTRY | | | |
| Silver Spring | | Holy Cross Hospital | | | | Teacher | | Music | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | |
| 13a. STATE | | | | | 13b. CITY OR TOWN | | 13c. STREET ADDRESS | | | | |
| Maryland | | | | | Howard | | 11034 Berrypick Lane | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | | |
| George A. Polley | | | | | Abigail H. Hulbert | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | |
| no | | | | | ? | | 11034 Berrypick Lane
Peter A. McCabe Columbia, Maryland 21044 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis.</u>
4291
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which
give rise to immediate
cause (a) stating the under-
lying cause last.
(b) <u>Chronic Myocardial Dis.</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u></u> | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
1 hr. |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
<u>None</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? | |
| <u>None</u> | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| | | | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion
death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL
SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE
SIGNED | | | |
| <u>[Signature]</u> | | | | M.D. <u>[Signature]</u> | | | | MEDICAL EXAMINER | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | | | ADDRESS | | | | | | | |
| | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| cremate | | 4/22/80 | | Westview Mem. Park | | | | Catonsville, Balto., Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| SLACK Funeral Home, Ellicott City, Maryland 21043 | | | | APR 24 1980 | | <u>[Signature]</u> | | | | | |

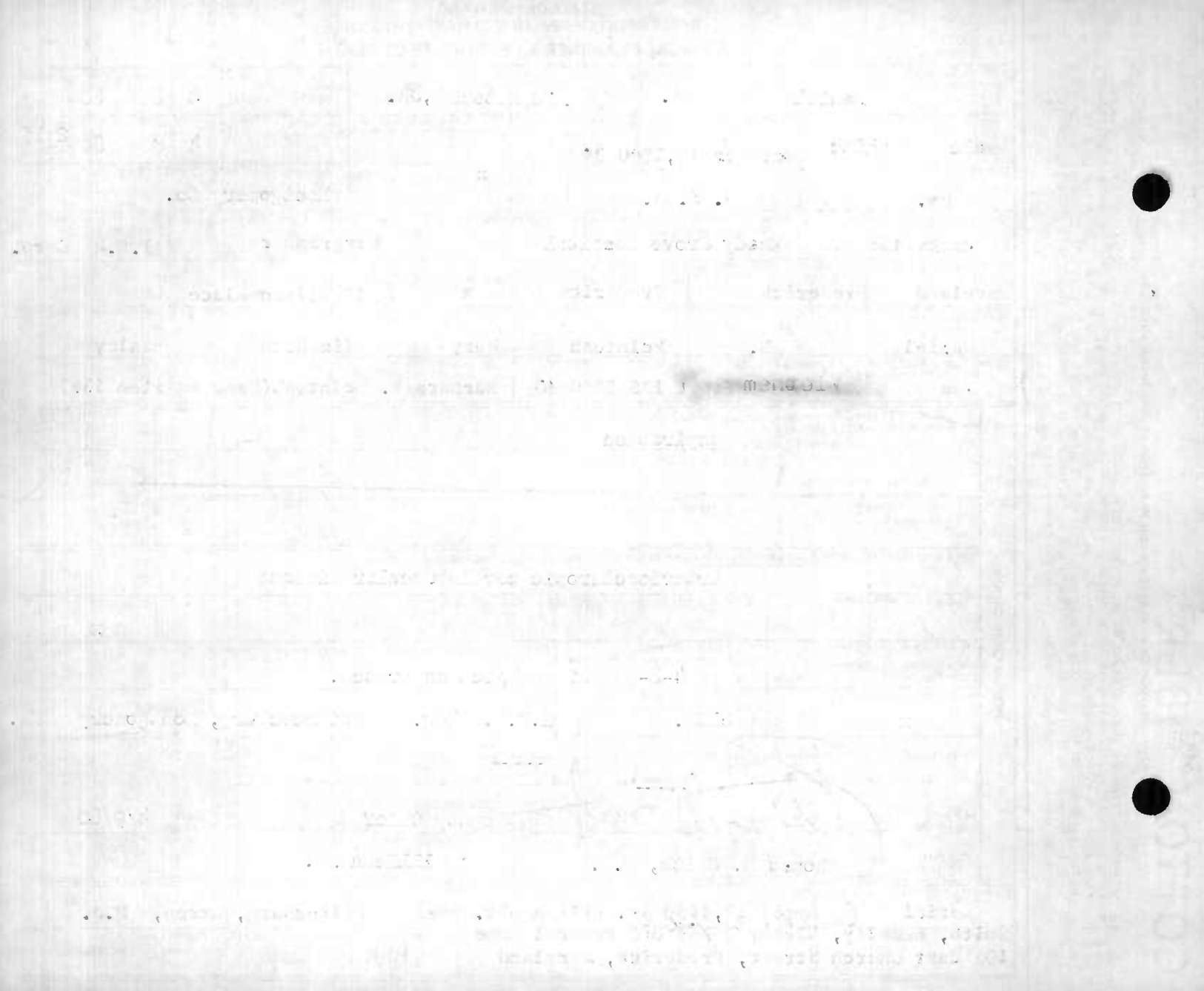
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS-301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 10745 | |
|---|--|----------------------|--|--|--|---|--|---|--|----------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Daniel A. Mc Intosh, JR. | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 4 8 19 80 | | 2b. HOUR 2:15 P M | | | |
| 3. SEX male | | 4. RACE white | | 5. DATE OF BIRTH
MONTH DAY YEAR October 19, 1940 39 YRS. | | 6. AGE (IN YEARS)
LAST BIRTHDAY MONTHS DAYS HOURS MIN | | 7c. DATE PRONOUNCED DEAD 4 8 19 80 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa. | | | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD. | | | |
| 10. CITY OR TOWN OF DEATH Rockville | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Programmer | | | |
| 13a. STATE Maryland | | | | 13b. CITY OR TOWN Frederick | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 512 Wilson Place | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST Daniel B. McIntosh | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST Mary Elizabeth Hanley | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) Yes | | | | 16b. SOCIAL SECURITY NO. 135 32 0040 | | 17. INFORMANT ADDRESS Barbara E. McIntosh (Same as item 13e) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Aspiration
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
Arteriosclerotic cardiovascular disease | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
? P.M. 4-8- 1980 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Subject aspirated. | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
bldg. | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
I.B.M. Bldg. Gaithersburg, Montgomery Md. | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Thomas D. Smith</i> | | | | TITLE (SPECIFY) Deputy Chief | | | | DATE SIGNED 4/9/80 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D. | | | | ADDRESS 111 Penn St. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE April 12, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY St. Philips & St. James | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Philipsburg, Warren, N.J. | | | |
| 24. NAME OF FUNERAL HOME Smith, Hanley, Keeney & Basford Funeral Home | | | | | | 25a. DATE REC'D. BY REGISTRAR APR 14 1980 | | 25b. REGISTRAR'S SIGNATURE <i>Robert McCready</i> | | | |
| 26. ADDRESS 106 East Church Street, Frederick, Maryland | | | | | | | | | | | |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

Item 6, G542 4/29/80 bal

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|---|--|--|--|--|--|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT) Elizabeth I. Meigs | | | 2a. DATE OF DEATH MONTH DAY YEAR
4 22 80 | | | 2b. HOUR
4 40 AM | | | |
| 3 SEX
FEMALE | | 4 RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
FEB 9, 1913 | | | 6 AGE (IN YEARS LAST BIRTHDAY)
67 77 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
ILLINOIS | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | |
| 10 CITY OR TOWN OF DEATH
TAKOMA PARK | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
WASHINGTON ADVENTIST HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
U.S. GOVERNMENT | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
WHEATON | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
12221 BERRY STREET | |
| 14 FATHER'S NAME FIRST MIDDLE LAST
WILLIAM | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
ADA GOULDING | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
347-10-4079 | | 17 INFORMANT
NEIGHBOR | | ADDRESS
12217 BERRY STREET WHEATON, MD. | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) SPINAL CORD METASTASIS
DUE TO, OR AS A CONSEQUENCE OF
(b) CARCINOMA OF BREAST
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 weeks
2 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/15 , 19 80 , to 4/22 , 19 80 , that (I) (we) last saw the deceased alive on 4/21 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
KIRKLAND C. BRACE | | | | | | DEGREE
MD | | 22c. DATE SIGNED
4/22/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
KIRKLAND C. BRACE | | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | |
| 22e. ADDRESS
1600 CARROLL AVE TAKOMA PARK | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | 23b. DATE
4/25/80 | | 23c. NAME OF CEMETERY OR CREMATORY
LUTHERAN CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
PEORIA ILLINOIS | | |
| 24 FUNERAL DIRECTOR
FRANCIS J. COLLINS
NAME ADDRESS
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | | 25. DATE REC'D. BY REGISTRAR
APR 25 1980 | | REGISTRAR'S SIGNATURE
Patricia McBrady | |

TOP SECRET

RECEIVED

ILLINOIS
U.S.A.
MONTGOMERY

TAMM PARK
MONTGOMERY

1937 BERRY STREET

CHARTER J. OGDEN
1937 BERRY STREET
MONTGOMERY

1937 BERRY STREET

1937 BERRY STREET

1937 BERRY STREET

1937 BERRY STREET

1937 BERRY STREET

1937 BERRY STREET

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|--|--|---|--|--|---|--|--|---|--|--|
| 1. FOR STATE REGISTRAR | | | 2a. DATE OF DEATH | | | MONTH DAY YEAR | | | 2b. HOUR | | |
| 1. DECEASED NAME
TYPE OR PRINT | | | FIRST MIDDLE LAST | | | 4 14 80 | | | 1 P M | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | |
| female | | | white | | | 11 MONTH 7 DAY 88 | | | 91 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Germany | | | USA | | | | | | Montgomery MD | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Kensington | | | Kensington Gardens Nursing Home | | | housewife | | | home | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 13b. STATE | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | |
| Maryland | | | Montgomery | | | Bethesda | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO | | |
| PETER | | | Schumann | | | Barbara | | | 17. INFORMANT ADDRESS | | |
| | | | | | | | | | Rose S. Doying same as 13c | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cardio-respiratory failure</u>
4140
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Arteriosclerotic heart disease & failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>embolic phenomenon</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 days
1 month | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>19 Dec 1</u> , 19 <u>80</u> , to <u>19 Dec</u> , 19 <u>80</u> , that (I/we) last saw the deceased alive on <u>31 Dec 11</u> , 19 <u>80</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I/we) did (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | | 22c. DATE SIGNED | | |
| <u>[Signature]</u> | | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | <u>9/14/80</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e. ADDRESS | | | | | |
| <u>John M. Kym...</u> | | | | | | <u>7841 Northgate Bethesda Maryland</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | |
| Cremation | | | 4/15/80 | | | Metropolitan Crematory | | | Alexandria, Virginia | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
| Tyson Wheeler Funeral Home, Inc.
1331 Rockville Pike Rockville, Md. 20852 | | | | | | APR 17 1980 | | | <u>[Signature]</u> | | |

4

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 10748 | | | |
|--|--|-------------------------------|--|---|--|---|--|--|-----------------------------------|--|--|--|--|
| 1- STATE REGISTRAR | | | | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Margaret K. Michaels</i> | | | | | | 2a. DATE KNOWN OF DEATH ESTI- MATED <i>April 10, 1980</i> | | 2b. HOUR OF DEATH <i>3:22</i> | | | | | |
| 3. SEX <i>F</i> | | 4. RACE <i>W</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>May 16 1920</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>70</i> YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD <i>April 12 1980</i> | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>PENNSYLVANIA</i> | | | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> | | | |
| 10. CITY OR TOWN OF DEATH <i>Silver Spring</i> | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Dr. & Cross Hosp</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>SUPERVISOR</i> | | | | 12b. KIND OF BUSINESS OR INDUSTRY <i>MARTIN AIRCRAFT</i> | |
| 13a. STATE <i>MARYLAND</i> | | 13b. COUNTY <i>MONTGOMERY</i> | | 13c. CITY OR TOWN <i>SILVER SPRING</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS <i>2410 KIMBERLY STREET</i> | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>CLYDE KETCHAM</i> | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>MAY WHITE</i> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>NO</i> | | | | 16b. SOCIAL SECURITY NO. <i>216-12-2521</i> | | 17. INFORMANT <i>HELEN K. HAMETZ</i> | | | | ADDRESS <i>SAME AS 13 SISTER</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Pulmonary Embolus</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) <i>Fracture Rt. Hip</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i></i> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>2 days</i> | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION <i>None</i> | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>PM 4:15 1980</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i>Fall while turning</i> | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, IN PUBLIC PLACE, OR IN HOME OF OTHER PERSON) <i>At home</i> | | 21f. LOCATION STREET CITY OR TOWN STATE <i>2051 Military Rd. N.W., Wash., D.C.</i> | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>John S. Rogers</i> | | | | | | TITLE (SPECIFY) <i>M.D.</i> | | | DATE SIGNED <i>April 20, 1980</i> | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) <i>JOHN S. ROGERS</i> | | | | | | ADDRESS <i>1919 SEMINARY ROAD, SILVER SPRING, MD.</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i> | | | | 23b. DATE <i>4/23/80</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>UNION CEMETERY</i> | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>WEATHERLY CARBON PA.</i> | | | |
| 24. FUNERAL DIRECTOR <i>FRANCIS J. COLLINS</i>
<i>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</i> | | | | | | 25a. DATE REC'D. BY REGISTRAR <i>APR 22 1980</i> | | 25b. REGISTRAR'S SIGNATURE <i>Robert McCreedy</i> | | | | | |

TELEPHONE NO. 1-234-5678
JAN 10 1964
MRS. J. D. SMITH
1234 MAIN ST.
SPRINGFIELD, ILL.
1-234-5678

RECEIVED
JAN 10 1964
MRS. J. D. SMITH
1234 MAIN ST.
SPRINGFIELD, ILL.
1-234-5678

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RECEIVED
JAN 10 1964
MRS. J. D. SMITH
1234 MAIN ST.
SPRINGFIELD, ILL.
1-234-5678

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMM-16 25M
(VRA 15, 4) 1/79

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8010749

FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|-------------------------------------|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <u>Virginia Mary Middleton</u> | | | 2a. DATE OF DEATH MONTH DAY YEAR <u>April 9 80</u> | | | 2b. HOUR <u>10¹⁰ A.M.</u> | | | |
| 3 SEX <u>Female</u> | | 4 RACE <u>White</u> | | 5 DATE OF BIRTH MONTH DAY YEAR <u>APR. 19 1911</u> | | 6 AGE (IN YEARS LAST BIRTHDAY) <u>68</u> YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Washington D.C.</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> MD. | | | |
| 10 CITY OR TOWN OF DEATH <u>Bethesda</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Suburban Hospital</u> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u> | | 12b. KIND OF BUSINESS OR INDUSTRY <u>--</u> | |
| 13a. STATE <u>--</u> | | | 13b. COUNTY <u>--</u> | | 13c. CITY OR TOWN <u>Wash. D.C.</u> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <u>Orin O. Groves</u> | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Elizabeth - Brewer</u> | | | 13e. STREET ADDRESS <u>4940 Rodman Street, N.W.</u> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u> | | 16b. SOCIAL SECURITY NO. <u>Unknown</u> | | 17 INFORMANT ADDRESS <u>T. Blair Middleton/ Husband/ Same as #13</u> | | | | | |

| | | | |
|---|--|---|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pulmonary Infarction</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u> | |
| 1832
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinomatous</u> | | 8 months | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Probable Adenocarcinoma of Fallopian Tube</u> | | 6 yrs | |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):
LEIOMYOMA OF UTERINE BED

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March 19 80</u> to <u>9 April 19 80</u> , that (I) (we) last saw the deceased alive on <u>9 April 19 80</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>Eugene P. Libre MD</u> | | | | DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>9 April 80</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>EUGENE P. LIBRE MD</u> | | | | 22e. ADDRESS <u>10400 CONNECTICUT AVE</u> <u>KEATING TOWNSHIP MD 20795</u> | | | |

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u> | | 23b. DATE <u>Apr. 12 1980</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Washington D.C.</u> | |
| 24 FUNERAL DIRECTOR NAME <u>Robert A. DeVol</u> | | 24b. ADDRESS <u>2222 Wsic. Ave. Washington D.C.</u> | | 25a. DATE REC'D. BY REGISTRAR <u>APR 15 1980</u> | | 25b. REGISTRAR'S SIGNATURE <u>Jeffrey McCreedy</u> | |

[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "Washington D.C." and "Department of State" are faintly visible.]

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|--|--|--|-----------------------------------|--------------------|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | |
| FIRST MIDDLE LAST
HANNA MEDZINSKI | | 4 9 80 | | | | 6:15 AM | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | | 8. IF UNDER 24 HRS | |
| FEMALE | WHITE | APRIL 24, 1924 | | 55 YRS. | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| POLAND | U.S.A. | | | MONTGOMERY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Silver Spring | Holy Cross Hospital | | | MERCHANT | | | GROCERY | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. STREET ADDRESS | | | |
| MARYLAND | | MONTGOMERY | | SILVER SPRING | | 8064 LANIER DRIVE | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | | |
| MORDCHAI | | GITTEL | | NO | | | | | |
| 17. INFORMANT | | 18. SOCIAL SECURITY NO. | | | | | | | |
| PINCHAS ZAHAVI | | 906 LOWANDER LANE, SILVER SPRING, MARYLAND | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Syndrome of increased intracranial pressure | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Right Frontal Intracerebral Hemorrhage | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| 3/9/80 | | Intracerebral Hematoma | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/9/80, 19 to 4/9, 19 80, that (I) (we) lost saw the deceased alive on 4/8, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DEGREE | | | | 22d. DATE SIGNED | | | |
| Barbara Jopale M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 4/9/80 | | | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22f. ADDRESS | | | | | | | |
| Barbara Jopale M.D. | | 5454 WISCONSIN AVENUE, CHEVY CHASE, MD. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | |
| BURIAL | | 4/10/1980 | | MOUNT LEBANON CEMETERY | | ADELPHI, PRINCE GEORGES, MD. | | | |
| 24. FUNERAL DIRECTOR | | 25. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME | | APR 14 1980 | | | | Rifky McCreedy | | | |
| 232 CARROLL STREET, N.W., WASHINGTON, D. C. | | | | | | | | | |

THE UNITED STATES

DEPARTMENT OF THE ARMY

WASHINGTON, D. C.

OFFICE OF THE ADJUTANT GENERAL
WASHINGTON, D. C.

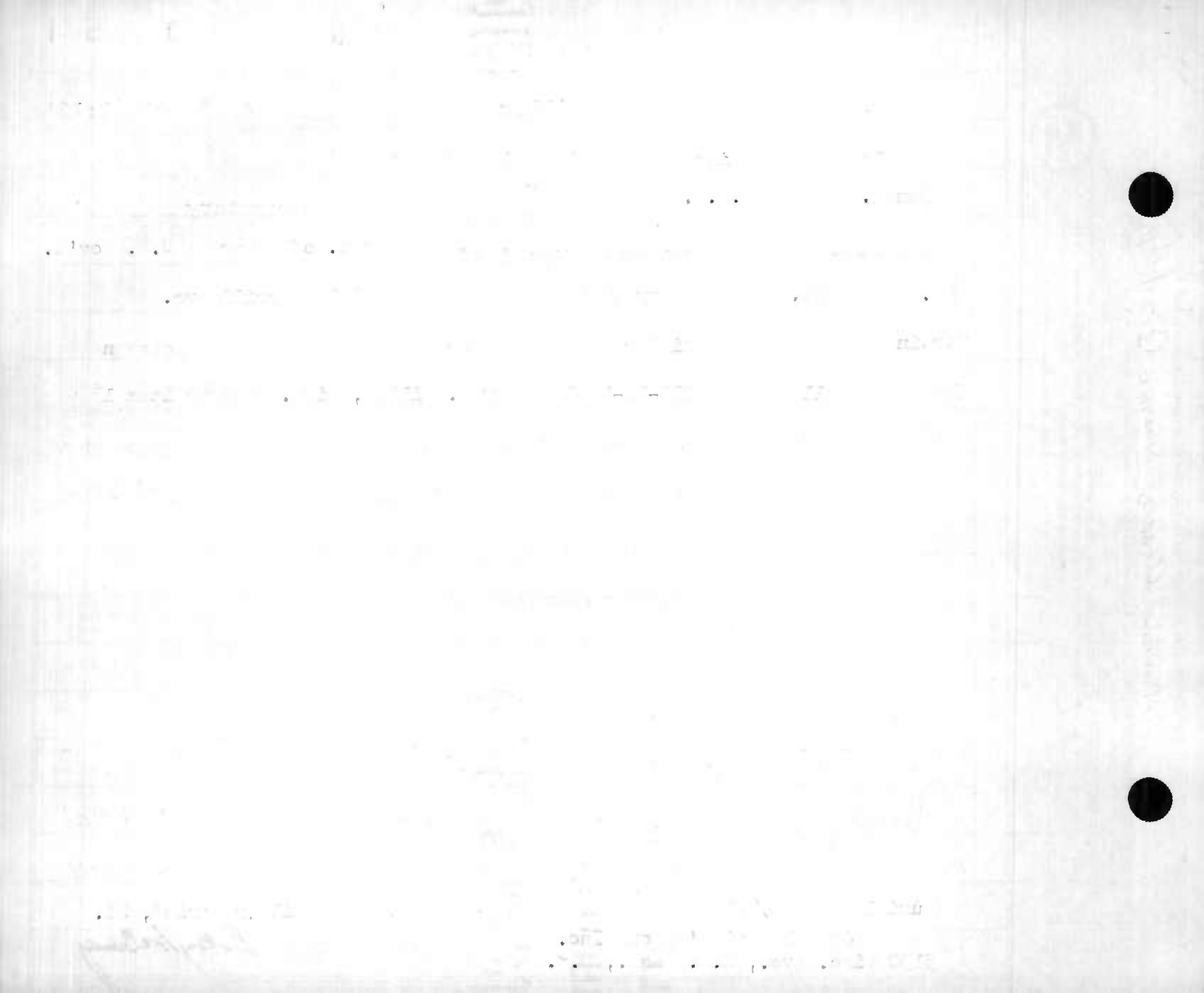
CORONER CLEARED SIGNING JOHN BELL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8010751 |
|--|--|--|--|---|---|--|--|--|--|---------|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
Fred G Miller | | | | | 2a. DATE OF DEATH
MONTH 4 DAY 5 YEAR 80 | | | 2b. HOUR
2:13AM | | |
| 3 SEX
Male | | 4 RACE
White | | 5 DATE OF BIRTH
MONTH 5 DAY 1 YEAR 05 | | 6. AGE (IN YEARS LAST BIRTHDAY)
74 YRS | | IF UNDER 1 YEAR
MONTHS 74 DAYS 74 HOURS 74 MIN 74 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Penna. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Dept. of Labor | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Gov't. | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE MD. COUNTY Mont. | | 13b. CITY OR TOWN
Chevy Chase | | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS
5301 Sherrill Ave. | | | | |
| 14. FATHER'S NAME
FIRST Martin MIDDLE Miller LAST Miller | | | 15. MOTHER'S MAIDEN NAME
FIRST Theresa MIDDLE Kotzman LAST Kotzman | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
WW11 | | 17. INFORMANT ADDRESS
Mary M. Miller, Wife. Same as item 13 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Ventricular Fibrillation
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease
DUE TO, OR AS A CONSEQUENCE OF (c) 4140
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 10+ years. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Immediate | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (we) attended the deceased from 1978 to APRIL 5 , 19 80 , that (I) (we) last saw the deceased alive on APRIL 2-24 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Alan M Weintraub MD | | | | DEGREE
MD | | | 22c. DATE SIGNED
4-6-80 | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ALAN M WEINTRAUB | | | | 22e. ADDRESS
5530 WISCONSIN AVE WASHINGTON DC | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
4/8/1980 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cemetery | | 23d. LOCATION
CITY OR TOWN Silver Spring COUNTY Md. STATE Md. | | | | |
| 24. FUNERAL DIRECTOR
NAME Joseph Gawler's Sons Inc.
ADDRESS 5130 Wisc. Ave., N.W. Wash., D.C. | | | | 25a. DATE REC'D. BY REGISTRAR
APR 9 1980 | | 25b. REGISTRAR'S SIGNATURE
Robert K. Kelley | | | | |

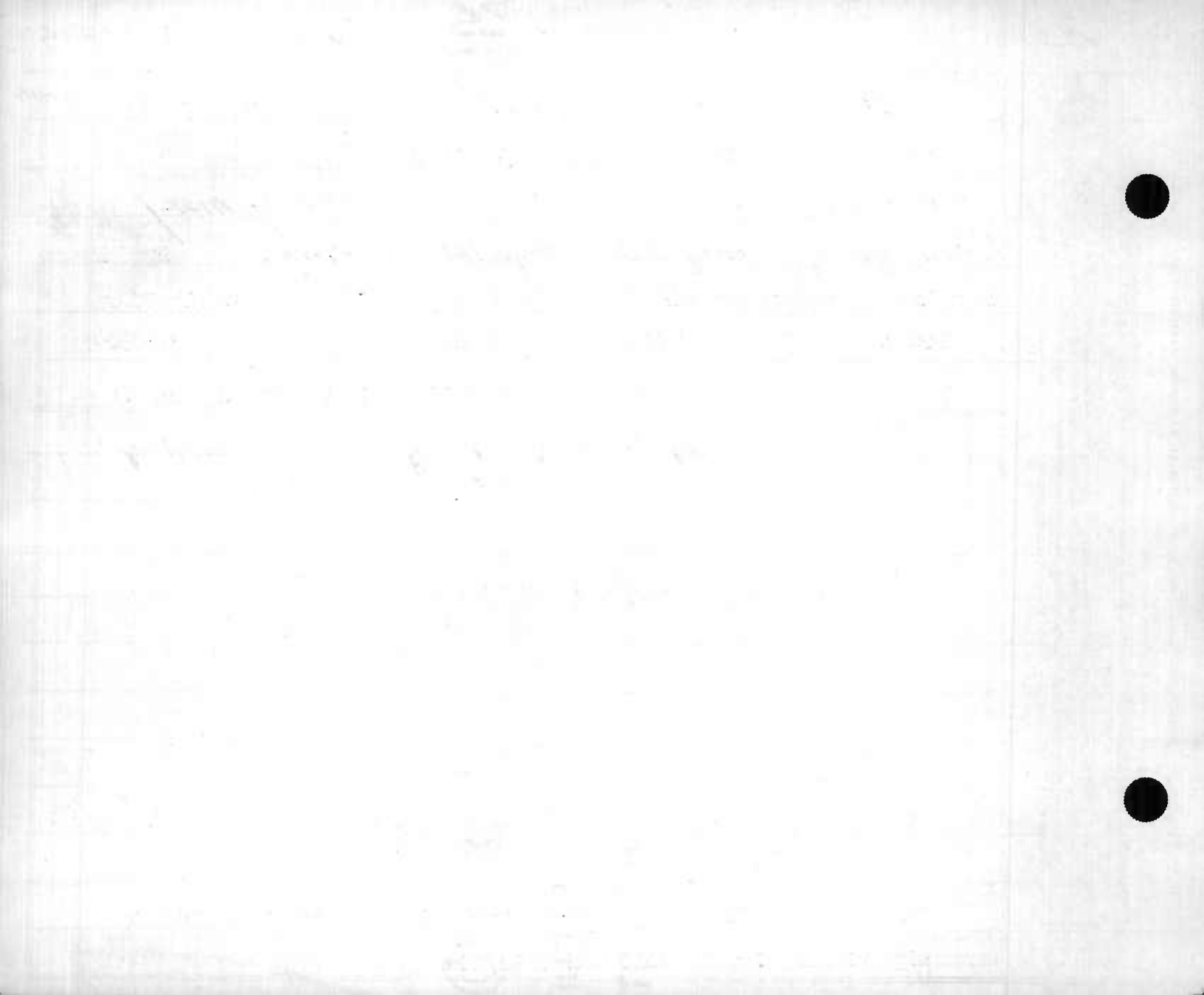


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 0 1 0 7 5 2 | | | |
|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) MORRIS P MILLER | | | | 2a. DATE OF DEATH MONTH DAY YEAR 4 14 80 | | 2b. HOUR 2 AM | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Oct. 19, 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Connecticut | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman | | 12b. KIND OF BUSINESS OR INDUSTRY Appliance | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland 13c. COUNTY Montgomery | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 11407 Columbia Pike | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Louis Miller | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nora (unknown) | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. WW II 041-18-4585 | | 17. INFORMANT ADDRESS Mary Miller; 11407 Columbia Pike; SSpq, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hepatic encephalopathy
5715
DUE TO, OR AS A CONSEQUENCE OF (b) Cirrhosis of liver
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Upper Gastro-intestinal bleeding | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (this hospital) attended the deceased from 4/12 19 80 , to 4/14 19 80 , that (we) lost the deceased alive on 4/14 19 80 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (not) view the body after death. | | | | | | | |
| 22b. SIGNATURE N. Rubenstein | | | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 4/14/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) NORMAN H. RUBENSTEIN | | | | 22e. ADDRESS 11161 NEW HAMPSHIRE AVE., SILVER SPRING, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 4-16-80 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington National | | 23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Virginia | |
| 24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels; 1170 Rockville Pike ADDRESS Rockville, Md. | | | | 25a. DATE REC'D. BY REGISTRAR APR 1 1980 | | 25b. REGISTRAR'S SIGNATURE Anthony McCreedy | |

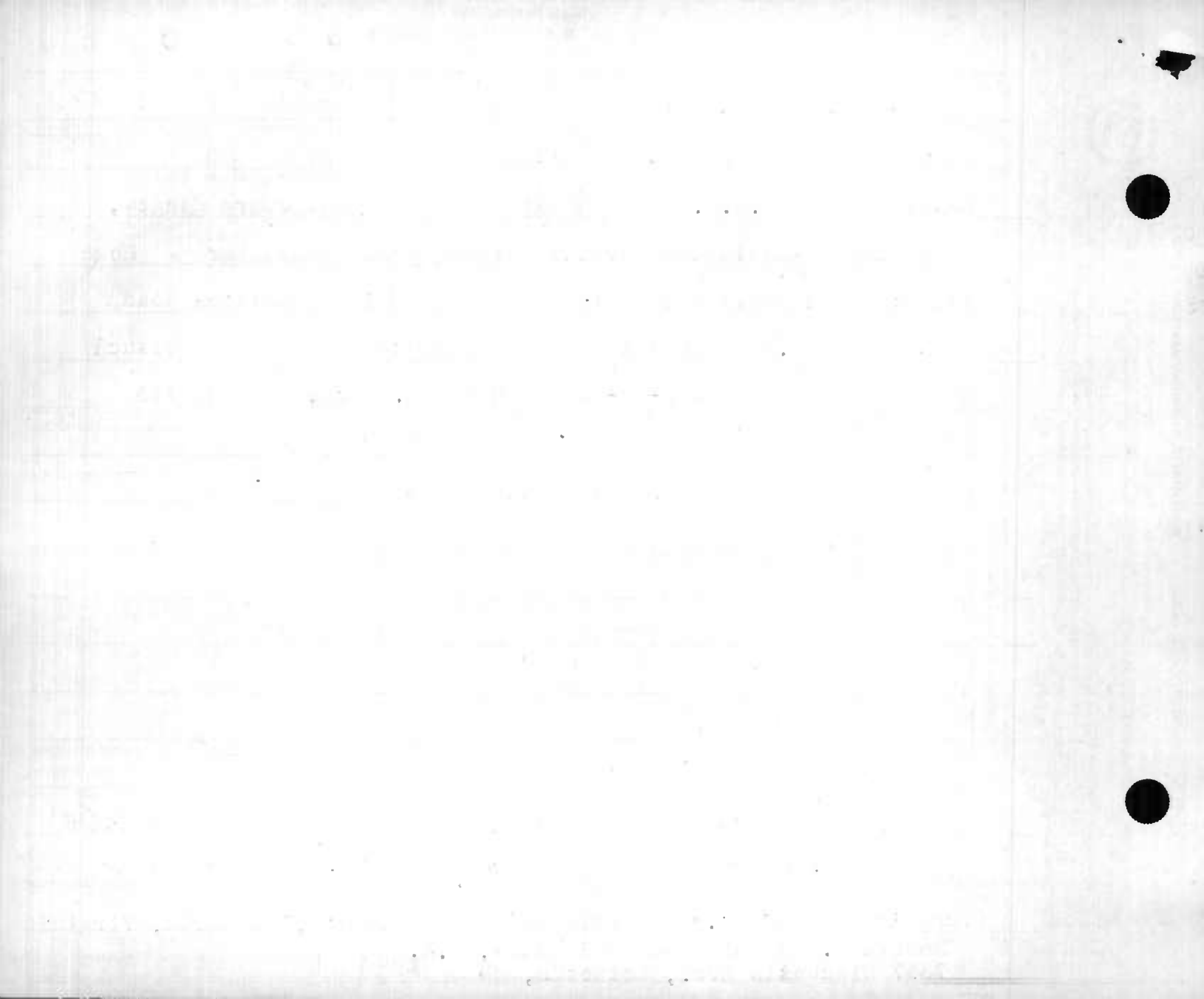


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post mortem examination should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8010153 | | | |
|---|--|---|--|---|--|--|--|
| FOR
1- STATE REGISTRAR | | | | REG. NO. | | | |
| 1 DECEASED NAME (TYPE OR PRINT) <i>Inez Howell Mock</i> | | | | 2a DATE OF DEATH MONTH DAY YEAR <i>April 9 '80</i> | | | |
| 3 SEX <i>Female</i> | | | | 2b HOUR <i>9 A M</i> | | | |
| 4 RACE <i>Caucasian</i> | | 5 DATE OF BIRTH MONTH DAY YEAR <i>6/2/1885</i> | | 6 AGE (IN YEARS LAST BIRTHDAY) <i>94</i> YRS. | | IF UNDER 1 YEAR MONTHS DAYS | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Kansas</i> | | 7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery County, MD.</i> | |
| 10 CITY OR TOWN OF DEATH <i>Kensington</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Kensington Gardens Nursing Home</i> | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i> | | 12b KIND OF BUSINESS OR INDUSTRY <i>Home</i> | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13a STREET ADDRESS | | | |
| 13a STATE <i>Maryland</i> | | 13b COUNTY <i>Montgomery</i> | | 13c CITY OR TOWN <i>Rockville</i> | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST <i>John H. Howell</i> | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Temperance Gorsuch</i> | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i> | | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>213-48-1822</i> | | 17 INFORMANT ADDRESS <i>Eugene H. Mock, same as #13</i> | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Coronary heart failure</i>
4140
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic heart disease</i>
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____ | | | | | | | |
| 19a DATE OF OPERATION <i>None</i> | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED _____ | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) _____ | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) _____ | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <i>April 14, 1980</i> to <i>present</i> , 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>Mar 26, 1980</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b SIGNATURE <i>John B. Umhauer MD</i> | | DEGREE <i>MD</i> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c DATE SIGNED <i>4/9/80</i> | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>John B. Umhauer MD</i> | | | | 22e ADDRESS <i>8805 Conn. Ave. Chevy Chase, Md.</i> | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i> | | 23b DATE <i>4/10/80</i> | | 23c NAME OF CEMETERY OR CREMATORY <i>Metropolitan Crematory Alexandria, Virginia</i> | | 23d LOCATION CITY OR TOWN COUNTY STATE | |
| 24 FUNERAL DIRECTOR NAME <i>Robert A. Pumphrey</i> | | | | 25a DATE REC'D. BY REGISTRAR <i>APR 15 1980</i> | | 25b REGISTRAR'S SIGNATURE <i>Robert A. Pumphrey</i> | |
| 7557 Wisconsin Ave., Bethesda, MD | | | | | | | |



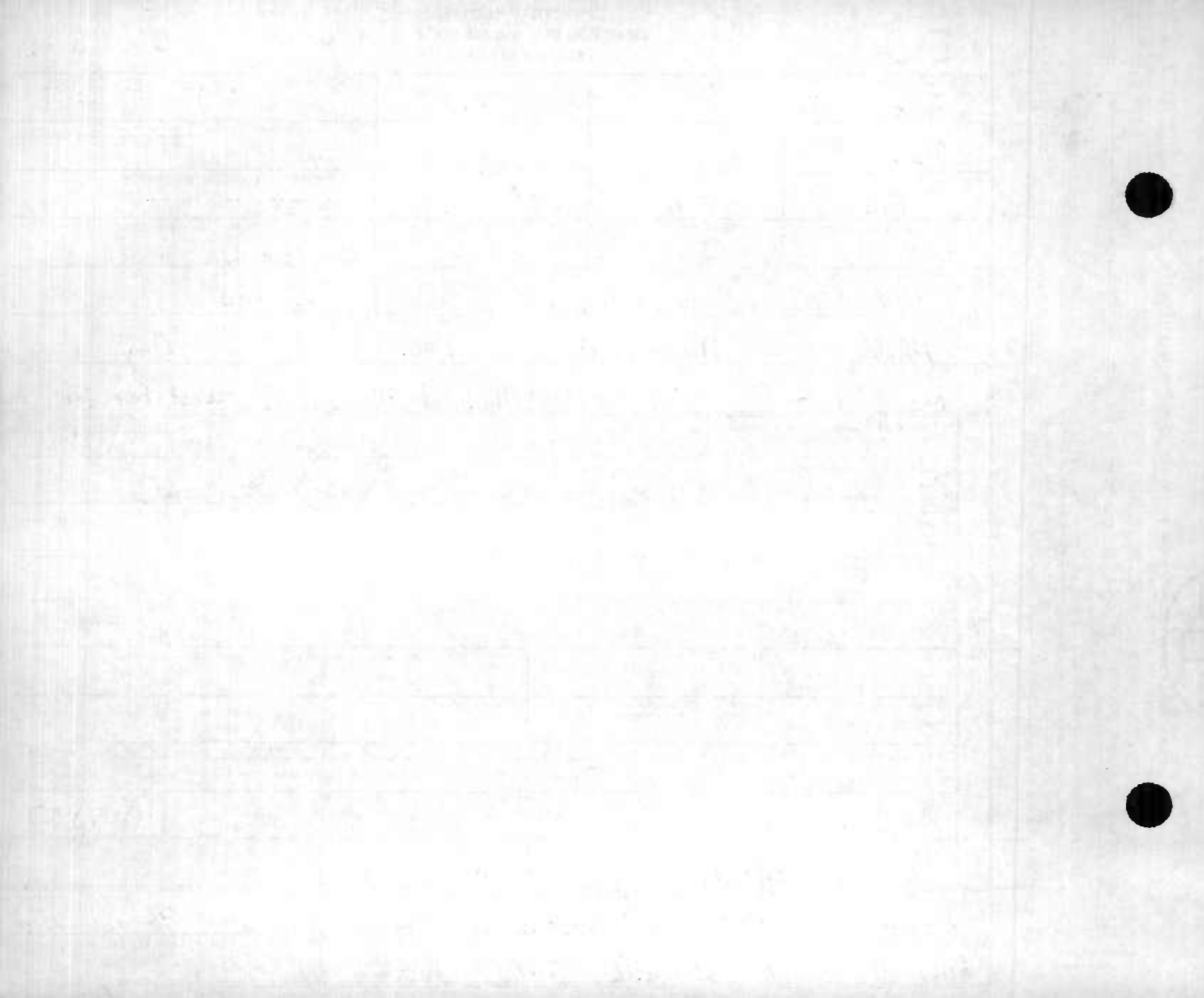
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 0 1 0 7 5 4 | |
|---|--|--|--|--|--|--|--|--|--|---------------|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Lewis EARL MOLESWORTH | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
4 15 80 | | 2b. HOUR
5:45PM | | | |
| 3 SEX
Male | | 4 RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
JAN. 17, 1906 | | 6 AGE (IN YEARS LAST BIRTHDAY)
74 | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
OLNEY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH CITY, GIVE STREET ADDRESS)
MONTGOMERY GENERAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Bus Driver | | 12b. KIND OF BUSINESS OR INDUSTRY
School | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE
Md. | | 13b. COUNTY
Howard | | 13c. CITY OR TOWN
West Friendship | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
Rt. 144 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
HARRY MOLESWORTH | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
LAURA DAY | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
216 32 9807 | | 17. INFORMANT ADDRESS
Mildred Molesworth West Friendship, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Acute myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary atherosclerotic heart disease
DUE TO, OR AS A CONSEQUENCE OF (c)
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.
410-
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4/12/80 | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.
4/12 19 80 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/12 19 80 to 4/15 19 80 , that (I) (we) last saw the deceased alive on 4/15 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
[Signature] | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
4/15/80 | | | |
| 22. PHYSICIAN'S NAME (TYPE OR PRINT)
G. Lodnell | | | | 22e. ADDRESS
Olney Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
Burial | | 23b. DATE
4-18-80 | | 23c. NAME OF CEMETERY OR CREMATORY
Howard Chapel Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Song Creek Howard Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME
Harry W. Haight | | | | ADDRESS
Sykesville, Md. | | 25a. DATE REC'D. BY REGISTRAR
APR 22 1980 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 8010755 | | | |
|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Other William Mongold | | | | 2b. HOUR
12:25 AM | | | |
| 3 SEX
Male | | 4 RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
March 27, 1913 | | 6 AGE (IN YEARS LAST BIRTHDAY)
67 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
West Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery Gen. Hosp. Olney Md. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Equipment Operator | | 12b. KIND OF BUSINESS OR INDUSTRY
Paving | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 13a. STATE
Maryland | | 13b. CITY OR TOWN
Montgomery | | 13c. STREET ADDRESS
20400 Frederick Rd., E 6 | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST
James Arley Mongold | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Cora Sites | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
235-18-7727 | | 17 INFORMANT ADDRESS
Nancy Renfrew, 542 Pheasant La. Clarksburg, Md. | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u>
1629
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Brain metastases</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Bronchogenic carcinoma, R lung</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
24 hrs
1 mo
1 yr | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) <u>this hospital</u> attended the deceased from <u>January</u> , 19 <u>80</u> , to <u>32 Apr</u> , 19 <u>80</u> , that (I) <u>last</u> saw the deceased alive on <u>21 Apr</u> , 19 <u>80</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did not</u> view the body after death. | | | | | | | |
| 22b. SIGNATURE
Donald E. Dillon MD | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
22 Apr 80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Donald E. Dillon, M.D. | | | | 22e. ADDRESS
18111 Prince Philip Dr., Olney, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
April 24, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Olivet | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Frederick, Frederick, Md. | |
| 24. FUNERAL DIRECTOR NAME
Olin L. Molesworth, Damascus, Md. | | | | 25a. DATE REG'D. BY REGISTRAR
APR 28 1980 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
M. J. McCreedy | | | |

137

W. G. 1906

09-11-10

Page 10 of 10

U.S. NO. 115, 9 H[er]roC

INTRO

John H. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the local health officer with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| 1. STATE REGISTRAR | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8010756 | | | |
|--|--|--|--|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | | 7b. HOUR | | | |
| BURDETTE H. MONROE | | | | 4/19/80 | | | | 3 ⁴⁵ A.M. | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7a. UNDER 1 YEAR | | 7c. UNDER 24 HRS. | |
| female | | white | | Jan. 22, 1912 | | 68 YRS. | | MONTHS | | DAYS | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7c. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Pennsylvania | | USA | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | Montgomery | | | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Silver Spring | | Holy Cross Hospital | | Vice-President | | Metropolis Bldg. & Loan | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| Maryland | | Pr. Geo. | | Hyattsville | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 5417 15th Avenue | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | | husband | | unknown | | | |
| Calvin | | Huffman | | | | William R. Monroe | | same as 13 | | | |
| 18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 18b. SOCIAL SECURITY NO. | | 19. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| No | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 18. CAUSE OF DEATH (Enter one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Carcinoma of Lung with distal pneumonia | | | | DUE TO, OR AS A CONSEQUENCE OF (b) | | | | DUE TO, OR AS A CONSEQUENCE OF (c) | | | |
| 1629 | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Congestive Heart Failure, Emphysema. | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | | 21d. PLACE OF INJURY | | 21e. LOCATION | | 21f. LOCATION | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | HOUR A.M. MONTH DAY YEAR P.M. 19 | | ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2 | | CITY OR TOWN | | COUNTY | | STATE | |
| 21a. INJURY OCCURRED | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | | 21d. PLACE OF INJURY | | 21e. LOCATION | | 21f. LOCATION | |
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500 University Blvd., N. Silver Spring, Md.
Francis J. Collins
Apr. 20, 1960
National Cancer Institute, Bethesda, Md.

Charles D. Lehmann, M.D.
10301 Georgia Avenue Silver Spring, Md.

Dr.
William F. Lehmann
same as Dr.
Lehmann
same as Dr.
Lehmann

Lehmann, Charles D.
10301 Georgia Avenue
Silver Spring, Md.
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Lehmann, Charles D.
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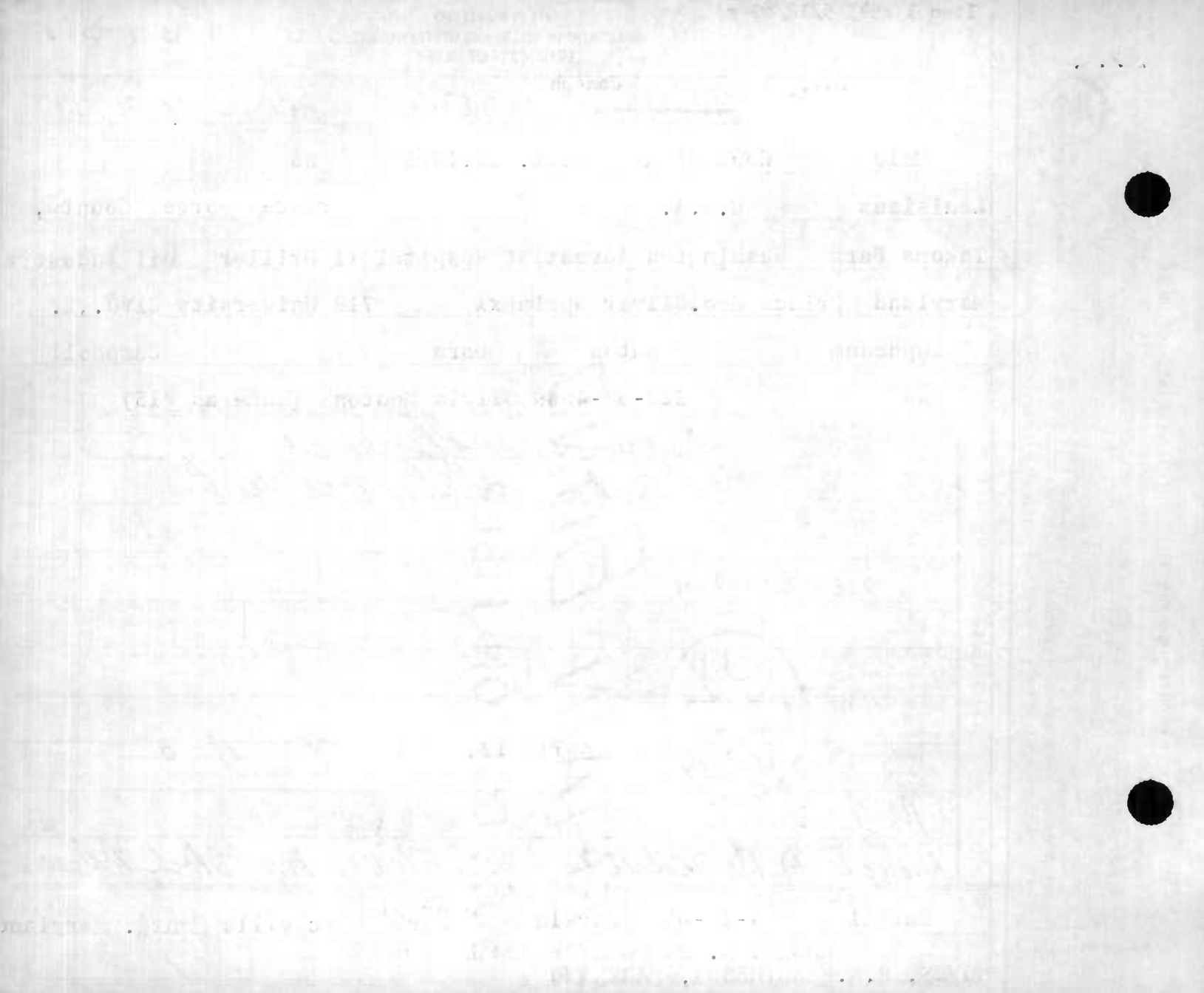
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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| Item 1 8543 5/12/80 gj | | | | | | | | | | STATE OF MARYLAND | | | | | | | | | |
| 1 - FOR STATE REGISTRAR | | | | | | | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | 7 0 1 0 7 5 7 | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) ^{FIRST} <u>Milton</u> ^{MIDDLE} <u>Joseph</u> ^{LAST} <u>MOUTON</u> | | | | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7b. HOUR <u>APRIL 17 '80</u> <u>1:45</u> M | | | | | | | | | |
| 3 SEX <u>Male</u> | | | | | 4 RACE <u>Caucasian</u> | | | | | 5 DATE OF BIRTH MONTH DAY YEAR <u>Sept. 23, 1893</u> | | | | | 6 AGE (IN YEARS LAST BIRTHDAY) <u>86</u> YRS. ^{IF UNDER 1 YEAR} MONTHS DAYS ^{IF UNDER 74 HRS} HOURS MIN | | | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Louisiana</u> | | | | | 7b CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9 BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery County, MD.</u> | | | | |
| 10 CITY OR TOWN OF DEATH <u>Takoma Park</u> | | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Washington Adventist Hospital</u> | | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Oil Driller</u> | | | | | 12b KIND OF BUSINESS OR INDUSTRY <u>Oil Industry</u> | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <u>Maryland</u> 13b COUNTY <u>Montgomery</u> 13c CITY OR TOWN <u>Silver Spring</u> 13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 13e STREET ADDRESS <u>719 University Blvd., E.</u> | | | | | | | | | |
| 14 FATHER'S NAME ^{FIRST} <u>Euphenom</u> ^{MIDDLE} <u>Mouton</u> ^{LAST} <u>Dora</u> | | | | | 15 MOTHER'S MAIDEN NAME ^{FIRST} <u>Dora</u> ^{MIDDLE} <u>Campbell</u> ^{LAST} <u>Campbell</u> | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u> | | | | | 16b SOCIAL SECURITY NO. <u>220-60-4689</u> | | | | | 17 INFORMANT ADDRESS <u>Olivia Mouton (Same as #13)</u> | | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebrovascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pneumonia</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Pneumonia</u> | | | | | | | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>19</u> | | | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>April 12, 1980</u> to <u>April 17, 1980</u> that (I) (we) last saw the deceased alive on <u>4/17/80</u> 19 <u>80</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) see the body after death. | | | | | | | | | | 22b. SIGNATURE <u>M. A. Rodriguez</u> DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | | | |
| 22c. DATE SIGNED | | | | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>MIGUEL A. RODRIGUEZ</u> | | | | | | | | | | 22e. ADDRESS <u>8634 Flower Ave. T. Park Md 20012</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | | | | 23b. DATE <u>4-19-80</u> | | | | | 23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Memorial Park</u> | | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Rockville Montg. Maryland</u> | | | | |
| 24. FUNERAL DIRECTOR NAME <u>ROBERT A. PUMPHREY FUNERAL HOMES, P.A. BETHESDA, MARYLAND</u> | | | | | | | | | | 25a. DATE RECEIVED BY REGISTRAR <u>APR 21 1980</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | | | | | | | |

2000 BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
MULLIGAN, NELLIE M. | | | | 2a. DATE OF DEATH MONTH DAY YEAR
4/2/80 | | 2b. HOUR
8:20A | |
| 3. SEX
Female | | 4. RACE
white | | 5. DATE OF BIRTH MONTH DAY YEAR
Jan. 13, 1894 | | 6. AGE (IN YEARS LAST BIRTHDAY)
86 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Wash. D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY | |
| 10. CITY OR TOWN OF DEATH
BETHESDA, | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SUBURBAN HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret. U.S. Gov. | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Wash. D.C. | | | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Dennis McCormick | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Monica Morgan | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
579 62 9807 | | 17. INFORMANT ADDRESS
204 East Joppa Rd. Balt. Md.
Rt. Rev. Leo L. McCormick (brother) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)
4/10 - Cardiac arrest
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
Myocardial ischemia
DUE TO OR AS A CONSEQUENCE OF
DUE TO OR AS A CONSEQUENCE OF
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 days | | | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from January 1962 to April 2 1980 , that (I) (we) last saw the deceased alive on April 1 1980 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
J. Blaine Fitzgerald M.D. | | | | | | 22c. DATE SIGNED
4/3/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
J. Blaine Fitzgerald, M.D. | | | | | | 22e. ADDRESS
8214 Wisc. Ave. Bethesda, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Apr. 5/80 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Olivet Cemetery Wash. D.C. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR NAME
W.W. Taltavull | | | | 25a. DATE REC'D. BY REGISTRAR
APR 7 1980 | | | |
| 25b. REGISTRAR'S SIGNATURE
Henry McCreedy | | | | | | | |

MULLIGAN, ELLIE M. 1/2/30 8:20

Female White Jan. 13, 1904

esp. D.C. USA NY MONTGOMERY

BETHESDA, SUBURBAN HOSPITAL Ref. U.S. Gov.

Wash. D.C.

Denise McCord Jones

no 529 1/2 2nd St. NW. 1st fl. Washington (D.C.)

3. 1st St. NW. 1st fl. Wash. D.C. Bethesda, Md.

4th fl. 1st St. NW. 1st fl. Wash. D.C. Bethesda, Md.

V.V. Tattavalli

Wash. D.C. 20014-1907

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 17 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8010759 | | | |
|--|--|--|--|---|--|--|--|---|--|------------------------------|-----|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a DATE OF DEATH | | MONTH | DAY | YEAR | 2b HOUR |
| William Francis Murphy | | | | | | | | April 24, 1980 | | | | | 6:22 P.M. |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| Male | | White | | April 12, 1916 | | 64 | | New York | | U.S.A. | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY | | 13a STATE | | 13b CITY OR TOWN | | 13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| Bethesda | | The Clinical Center | | Seaman | | Merchant Marines | | Florida | | Pasco | | Port Richey | |
| 14 FATHER'S NAME | | 15 MOTHER'S MAIDEN NAME | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT | | 18 ADDRESS | | | |
| William | | Margaret McGlynn | | Yes | | 050-07-1123 | | Mrs. Rose Murphy | | (Same as Above) | | | |
| 19 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1 DEATH WAS CAUSED BY: | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION/Right | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE | | | | | | | | | | | | | VENTRICULAR LACERATION |
| DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Severe Atherosclerosis | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 4/24/80 | | CORONARY ARTERY DISEASE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | P.M. | | 19 | |
| 21d INJURY OCCURRED | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION | | 21g CITY OR TOWN | | 21h COUNTY | | 21i STATE | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | STREET | | CITY OR TOWN | | COUNTY | | STATE | | | |
| 22a I certify that (X) (this hospital) attended the deceased from April 20, 1980, to April 24, 1980, that (X) we last saw the deceased alive on April 24, 1980, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) we did not see the body after death. | | | | | | | | | | | | | |
| 22b SIGNATURE | | 22c DEGREE | | 22d DATE SIGNED | | 22e ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22f ADDRESS | | 22g CITY OR TOWN | | 22h COUNTY | |
| J.B. Zwischenberger M.D. | | | | 4/25/80 | | | | THE NATIONAL INSTITUTES OF HEALTH | | BETHESDA, MD. | | 20205 | |
| 22i PHYSICIAN'S NAME (TYPE OR PRINT) | | 22j ADDRESS | | 22k CITY OR TOWN | | 22l COUNTY | | 22m STATE | | 22n DATE REC'D. BY REGISTRAR | | 22o REGISTRAR'S SIGNATURE | |
| J.B. Zwischenberger M.D. | | THE CLINICAL CTR., BETHESDA, MD. 20205 | | | | | | | | MAY 1 1980 | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION | | 23e CITY OR TOWN | | 23f COUNTY | | 23g STATE | |
| Burial | | 4-30-80 | | Calverton Nat'l Cem. | | Calverton | | New York | | | | | |
| 24 FUNERAL DIRECTOR NAME | | 24b ADDRESS | | 24c CITY OR TOWN | | 24d COUNTY | | 24e STATE | | 24f DATE REC'D. BY REGISTRAR | | 24g REGISTRAR'S SIGNATURE | |
| ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND | | | | | | | | | | MAY 1 1980 | | | |

11-2-41

Nov 11

STATION

REPORT

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City

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REPORT

Nov 11

Investigation and Report

11-2-41

Nov 11

UNITED STATES DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF INVESTIGATION

WASHINGTON, D. C. 20535

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of page.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8010760
REG. NO.

| | | | | | |
|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | MONTH DAY YEAR | |
| HARRY | | NEGREANU | | APRIL 6, 1980 | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | |
| MALE | | WHITE | | MAY 18, 1908 | |
| 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 71 | | U.S.A. | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| MONTHS DAYS HOURS MIN. | | 10. CITY OR TOWN OF DEATH | | MONTGOMERY | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| HOLY CROSS HOSPITAL | | SALESMAN | | RETAIL | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. INSIDE CITY LIMITS? | | 13c. STREET ADDRESS | |
| 13a. STATE 13b. COUNTY | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 8128 15th AVENUE, APT. 204 | |
| MARYLAND PR. GEORGES | | HYATTSVILLE | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | |
| LEIBU | | MIRTZA | | MANDELBAUM | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | 285-46-6122 | | MARCELA NEGREANU, same as #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) <u>Histiocytic lymphoma</u> | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (b) _____ | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) _____ | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | |
| | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from | | 2/19 19 80 | | to 4/6 19 80 | |
| saw the deceased alive on | | 4/6 19 80 | | and that in (my) (our) opinion death occurred on the date and hour and from the causes stated | |
| above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| Norman H. Rubenstein | | M.D. | | 4/7/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| NORMAN H. RUBENSTEIN, M.D. | | 11161 NEW HAMPSHIRE AVENUE,
SILVER SPRING, MARYLAND | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| BURIAL | | 4/9/1980 | | MOUNT LEBANON CEMETERY | |
| 23d. LOCATION | | 23e. DATE REC'D. BY REGISTRAR | | 23f. REGISTRAR'S SIGNATURE | |
| CITY OR TOWN COUNTY STATE | | APR 10 1980 | | [Signature] | |
| ADELPHI PRINCE GEORGES, MD. | | | | | |
| 24. FUNERAL DIRECTOR | | | | | |
| DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME | | | | | |
| 232 CARROLL STREET, N. W., WASHINGTON, D.C. | | | | | |

Cleared by Dr. Ball, Medical Examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|---|---|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Marie L. Nichols</i> | | | | | 2a. DATE OF DEATH
MONTH <i>4</i> DAY <i>2</i> YEAR <i>80</i> | | | | | 2b. HOUR
<i>0610</i> M |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>Caucasian</i> | | 5. DATE OF BIRTH
MONTH <i>Dec.</i> DAY <i>25</i> YEAR <i>1891</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>88</i> YRS | | 7. IF UNDER 1 YEAR
MONTHS <i></i> DAYS <i></i> | | 8. IF UNDER 24 HRS
HOURS <i></i> MIN <i></i> |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery</i> MD. | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Rockville, MD</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>SHADY GROVE ADVENTIST HOSP</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Retired housekeeper</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Funeral Home</i> | | |
| 13a. STATE
<i>Maryland</i> | | 13b. COUNTY
<i>Montgomery</i> | | 13c. CITY OR TOWN
<i>Rockville</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
<i>13765 Travilah Rd.</i> | | |
| 14. FATHER'S NAME
FIRST <i>(NOT AVAILABLE)</i> MIDDLE <i></i> LAST <i>Bennett</i> | | | | | 15. MOTHER'S MAIDEN NAME
FIRST <i>(NOT AVAILABLE)</i> MIDDLE <i></i> LAST <i></i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>no</i> | | 16b. SOCIAL SECURITY NO
<i>NOT AVAILABLE</i> | | 17. INFORMANT
ADDRESS
<i>Geo. L. Roberts (same as 13e)</i> | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <i>Cardiogenic shock</i>
<i>4140</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Arteriosclerotic + Valvular Heart Disease</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF
(c) <i></i>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>< 24 hrs</i>
<i>> 8 yrs.</i> | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<i>Respiratory insuff., hyponatremia, acidosis, pulmonary edema, anemia.</i> | | | | | | | | | | |
| 19a. DATE OF OPERATION
<i>April 2 1980</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i></i> | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET
<i></i> | | CITY OR TOWN
<i></i> | | COUNTY
<i></i> | | STATE
<i></i> |
| 22. I certify that (I) (this hospital) attended the deceased from <i>April 1 1980</i> to <i>April 2 1980</i> , that (I) (we) last saw the deceased alive on <i>April 1 1980</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22a. SIGNATURE
<i>Donald E. Dillon</i> | | | | | DEGREE
<i></i> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<i>Apr 2 1980</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Dr. Philip Br Olney MD 20832</i> | | | | | 22e. ADDRESS
<i>Donald E. Dillon, M.D.</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>4-4-80</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Forest Oak Cemetery</i> | | 23d. LOCATION
CITY OR TOWN
<i>Gaithersburg Montg.</i> | | COUNTY
<i>Maryland</i> | | STATE
<i></i> |
| 24. FUNERAL DIRECTOR
NAME
<i>ROBERT A. PUMPHREY FUNERAL HOMES P/A</i> | | | | | ADDRESS
<i>ROCKVILLE MD.</i> | | 25a. DATE REC'D. BY REGISTRAR
<i>APR 9 1980</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Robert A. Pumphrey</i> | |



| | | | |
|-----------------|---|--------------|--------------------|
| Female | Caucasian | Dec. 25 1901 | 88 |
| Maryland | U.S.A. | X | Montgomery |
| (NOT AVAILABLE) | (NOT AVAILABLE) | X | 13265 Travilah Rd. |
| no | NOT AVAILABLE Dec. 1. Roberts (same as 136) | | |

Current A. HARRIS RURAL HOMES P.A. - NO. 1
APR 9 1980
ROCKVILLE
Forest Oak Cemetery - Baltimore, Maryland
Burial 4-8-80

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 0 1 0 7 6 2 | | | |
|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR <i>Joan</i> | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
<i>Joan F Nolan</i> | | | | 2a. DATE OF DEATH MONTH DAY YEAR
<i>4 6 80</i> | | 2b. HOUR
<i>4 40 1 M</i> | |
| 3. SEX
<i>F female</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH MONTH DAY YEAR
<i>11 25 30</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS
<i>49</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>MASSACHUSETTS</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>MONTGOMERY</i> MD. | |
| 10. CITY OR TOWN OF DEATH
<i>BETHESDA</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>SUBURBAN HOSPITAL</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>ARTIST</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13b. STREET ADDRESS
<i>14600 MYER TERRACE</i> | |
| 13a. STATE
<i>MARYLAND</i> | | 13b. COUNTY
<i>MONTGOMERY</i> | | 13c. CITY OR TOWN
<i>ROCKVILLE</i> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
<i>JOHN</i> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
<i>MARY BAGAN</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
<i>NO</i> | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)
<i>071-24-3492</i> | | 17. INFORMANT ADDRESS
<i>GERARD D. NOLAN SAME AS 13 HUSBAND</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiorespiratory Failure</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cardioma</i>
(c) <i>Carcinoma of colon metastases</i> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>2 hrs</i>
<i>2 mos</i>
<i>3 yrs</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19a. DATE OF OPERATION
<i>1977</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>Ca colon</i> | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
<i>P.M. — 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>1977</i> , 19 <i>80</i> , to <i>4-5</i> , 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>4-5</i> , 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Richard M. Huld</i> | | | | DEGREE
<i>PH.D.</i> | | 22c. DATE SIGNED
<i>4/6/80</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>RICHARD M. HULD</i> | | | | 22e. ADDRESS
<i>809 VIERs Mill Rd. Rockville, Md.</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>BURIAL</i> | | 23b. DATE
<i>4/9/80</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>CULPEPER NATIONAL</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE
<i>CULPEPER VIRGINIA</i> | |
| 24. FUNERAL DIRECTOR NAME
<i>FRANCIS J. COLLINS</i> | | | | 25a. DATE REC'D. BY REGISTRAR
<i>APR 9 1980</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Richard M. Huld</i> | |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | | | |

1972
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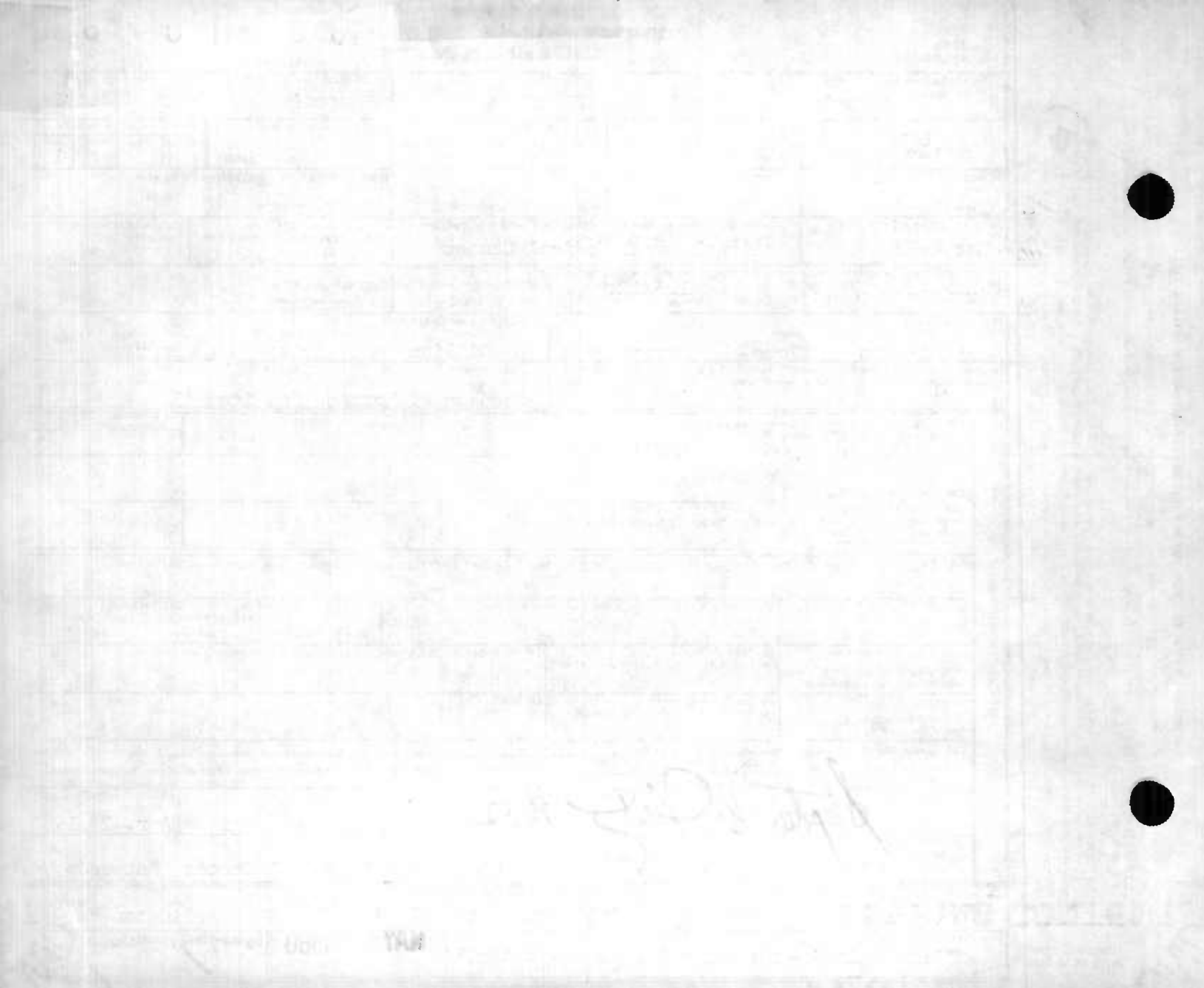
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

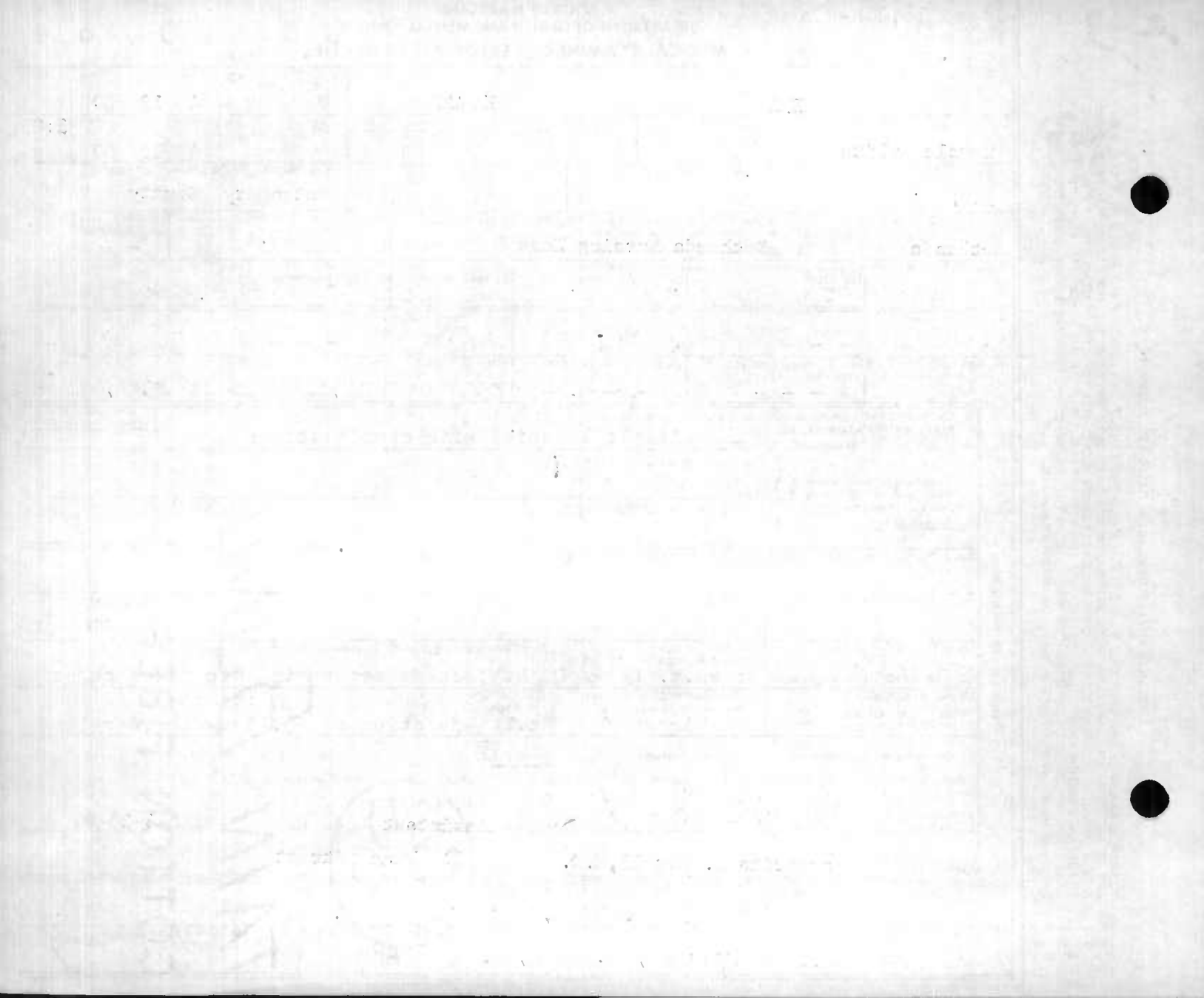
MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 0 1 0 7 6 3 | | | |
|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) Stephanie Hazel NORTON | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
April 26 1980 | | 2b. HOUR
5:23P M | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
April 26 1980 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS
0 0 0 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
National Naval Medical Center | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
N/A | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Virginia | | | | 13b. CITY OR TOWN
Arlington | | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Stephen Ross Norton | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Gillian Iris Andrews | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
N/A | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
N/A | | 17. INFORMANT
ADDRESS
Stephen R. Norton See item 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1: DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Immaturity
7651
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Apr. 26 , 19 80 , to Apr. 26 , 19 80 , that (I) (we) last saw the deceased on Apr. 26 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22a. SIGNATURE
<i>Stephen A. Metz</i> | | | | DEGREE
M.D.
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
Apr. 28, 1980 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Stephen A. Metz, M.D. | | | | 22e. ADDRESS
National Naval Medical Center, Bethesda, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
5/1/80 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arlington Arlington Va | |
| 24. FUNERAL DIRECTOR
NAME
Murphy Arlin-ton Funeral Home, Arlington, Va. | | | | 25. FILED BY REGISTRAR
May 5 1980 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 10764 | |
|--|--|--|--|--|--|--|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) IDA OSHWETZ | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 4 19 80 | |
| 3. SEX female 4. RACE white 5. DATE OF BIRTH MONTH DAY YEAR 7/1/1901 6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS. IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | | | | | | | | 2b. HOUR 9:00 P.M. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD. | | |
| 10. CITY OR TOWN OF DEATH Bethesda | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bethesda Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | | 12b. KIND OF BUSINESS OR INDUSTRY - - | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE NEW YORK | | | 13b. COUNTY KINGS | | 13c. CITY OR TOWN NEW YORK | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1975 83rd STREET | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ABRAHAM - - - SCHWARTZ | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA - - - (unknown) | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. 093-22-5313-A | | 17. INFORMANT EVELYN NORWITZ | | | ADDRESS 12304 SURREY CI. DR, OXON HILL MD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries with complications
8151
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3:00 P.M. 2/24/80 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject passenger in auto fixed object impact | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) highway | | 21f. LOCATION CITY OR TOWN Rt. 1 & junction of 95, Edgewater, Maryland COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE Margie Be Kill | | | | TITLE (SPECIFY) Assistant | | | | DATE SIGNED 4-20-80 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. | | | | ADDRESS 111 Penn Street | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 4/21/80 | | 23c. NAME OF CEMETERY OR CREMATORY MT. HEBRON, CEMETERY | | | 23d. LOCATION CITY OR TOWN FLUSHING COUNTY NEW YORK STATE | | | |
| 24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEM. CHAPELS, ROCKVILLE, MD. ADDRESS | | | | | | 25a. DATE REC'D. BY REGISTRAR APR 28 1980 | | 25b. REGISTRAR'S SIGNATURE Mary M. Brady | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

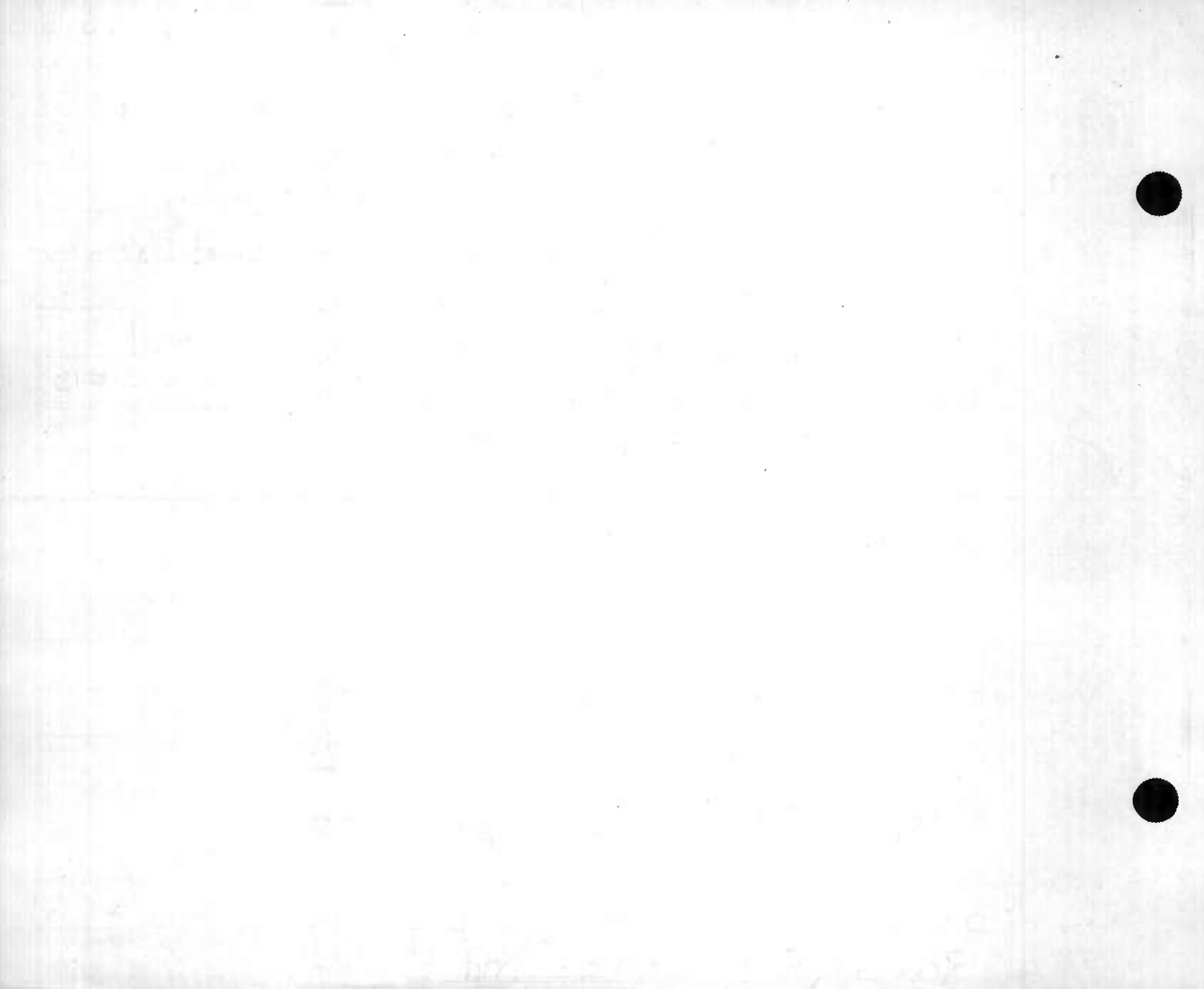
DHMH-16 20M
(VRA 15, 4) 7/78

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|--|--|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
James J. Paddy | | | 2a. DATE OF DEATH
MONTH DAY YEAR
4-16-80 | | | 2b. HOUR
3:32 M | | | | |
| 3. SEX
Male | | 4. RACE
W. | | 5. DATE OF BIRTH
MONTH DAY YEAR
3 13 15 | | 6. AGE (IN YEARS LAST BIRTHDAY)
65 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 9. CITIZEN OF WHAT COUNTRY?
USA | | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | | | | |
| 12. CITY OR TOWN OF DEATH
Towson Park | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Robert Hospital | | | | 14. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Self employed | | 15. KIND OF BUSINESS OR INDUSTRY
Contractor | | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
16a. STATE Md 16b. COUNTY Calvert 16c. CITY OR TOWN Beach | | | | | 17. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 18. STREET ADDRESS
Box 31 | | | |
| 19. FATHER'S NAME
FIRST MORTIS MIDDLE Paddy LAST | | | | | 20. MOTHER'S MAIDEN NAME
FIRST Helen MIDDLE E LAST Hall | | | | | |
| 21a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | | 21b. SOCIAL SECURITY NO
(IF YES, GIVE WAR OR DATES)
1943-1945 213018081 | | 22. INFORMANT
Mar 140 E. Paddy | | | | 23. ADDRESS
Same as #13 | |
| 24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY
1629 IMMEDIATE CAUSE (a) <u>Brainogenic carcinoma</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Left Unknown</u> | | | | | | | | | | |
| 25a. DATE OF OPERATION | | | 25b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 26a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 26b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 27a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 27b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 27c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 28a. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 28b. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 28c. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 29. I certify that (I) (this hospital) attended the deceased from Feb 1980 to April 16 1980, that (I) (we) lost
saw the deceased alive on April 16 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 30. SIGNATURE
Sig William Wance | | | | | 31. DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 32. DATE SIGNED | | |
| 33. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 34. ADDRESS
9801 Georgia Ave Silver Spring Md | | | | | |
| 35. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 36. DATE
4-19-80 | | 37. NAME OF CEMETERY OR CREMATORY
Mt Harmony | | 38. LOCATION
CITY OR TOWN COUNTY STATE
Owings Calvert Md | | | |
| 39. FUNERAL DIRECTOR
Rauoch Funeral Home | | | | | 40. ADDRESS
Owings Md | | | | | |
| 41. DATE REC'D. BY REGISTRAR | | | | | 42. REGISTRAR'S SIGNATURE
APR 23 1980 | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 355-9015.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | MONTH DAY YEAR | | HOURS MIN. | |
| LLOYD | | J. | | PAGE | | | | 4-29-80 | | 5:48 A.M. | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | | 8. IF UNDER 24 HRS | |
| Male | | White | | 12 MONTH 16 DAY 1899 | | 80 YRS. | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Maryland | | USA | | | | Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Takoma Park | | Sligo Gardens Nursing Home | | | | | | Retired | | U.S. Govt., | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| Maryland | | Montgomery | | Sil. Spring | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 613 Mississippi Avenue, | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| FIRST MIDDLE LAST | | | | FIRST MIDDLE LAST | | | | | | | |
| Frank M. Page | | | | Isabella (unknown) | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT (daughter) ADDRESS | | | | | |
| no | | | | none | | 218-38-9201 Aileen Kimbrough-Fayetteville, Ark. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis Generalized</u> DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Laryngeal Cancer, Hypothyroidism</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>14 Apr 1980</u> to <u>29 Apr 1980</u> , that (I) (we) last saw the deceased alive on <u>29 Apr 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | DEGREE | | 22c. DATE SIGNED | |
| Thomas P. Fogarty, MD. | | | | | | | | MD | | 29 Apr 80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | 22e. ADDRESS | | | |
| Thomas P. Fogarty, MD. | | | | | | | | 7676 N.H. Avenue, Langley Park, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | | | 5-1-1980 | | St. Johns Cemetery Forest Glen | | | | Montg. Md. | |
| 24. FUNERAL DIRECTOR | | | | | | | | 25. DATE REC'D. BY REGISTRAR (SEE REGISTRAR'S SIGNATURE) | | | |
| Warner E. Pumphrey, Inc. | | | | | | | | 1 MAY 1 1980 | | | |
| 8434 Ga. Ave., S.S., Md. | | | | | | | | Chad E. Wilson | | | |

Circle 342

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 10167 | | | |
|--|--|---------------------|--|--|--|--|--|---|--|---|--|-------------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Enguicio Palacios | | | | | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED April 24 1980 | | 2b. HOUR
9:45 AM | |
| 3. SEX
F | | 4. RACE
W | | 5. DATE OF BIRTH
MONTH DAY YEAR Dec 26 99 | | 6. AGE (IN YEARS)
LAST BIRTHDAY 80 YRS. | | 7. IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
April 24 1980 | | 2d. HOUR
9:45 AM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Nicaragua | | | | 7b. CITIZEN OF WHAT COUNTRY?
Nicaraguan | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Sil. Spg. | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hosp | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Not Stated | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD | | | | 13b. COUNTY
Mont | | 13c. CITY OR TOWN
Sil. Spg. | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
810 Northampton Dr. | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Fernando Placio | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Francisca Tryerino | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
NO | | | | 16b. SOCIAL SECURITY NO.
Not Stated | | 17. INFORMANT
Antonio Diaz, Son, 810 Northampton Dr. | | | | ADDRESS
S. S. Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
888- Subdural hematoma | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
11 days | | | |
| IMMEDIATE CAUSE (a) F211 | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) F211 | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
None | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
April 24 1980 | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
Subdural hematoma | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR MIN. MONTH DAY YEAR
4:00 P.M. 4-13-80 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Fell on floor at home | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
Home | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
Northampton Dr. Sil. Spg. Mont MD | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
[Signature] | | | | TITLE (SPECIFY)
M.D. Dep | | | | MEDICAL EXAMINER | | | | DATE SIGNED
April 24 1980 | |
| EXAMINER'S NAME
(TYPE OR PRINT)
[Signature] | | | | ADDRESS
[Signature] | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
26 Apr 80 | | 23c. NAME OF CEMETERY OR CREMATORY
Mount Olivet Cemetery | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington, D.C. | | | |
| 24. FUNERAL DIRECTOR
NAME
W. Ernest Jarvis Co., Inc., | | | | ADDRESS
1432 You Street, N.W. | | | | DATE REC'D. BY REGISTRAR
MAY 1 1980 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

1. The first part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom. It is shown that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are derived from the principles of relativity and the theory of the structure of the atom.

2. The second part of the paper is devoted to a discussion of the application of the theory of the structure of the atom to the problem of the structure of the nucleus. It is shown that the structure of the nucleus is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are derived from the principles of relativity and the theory of the structure of the atom.

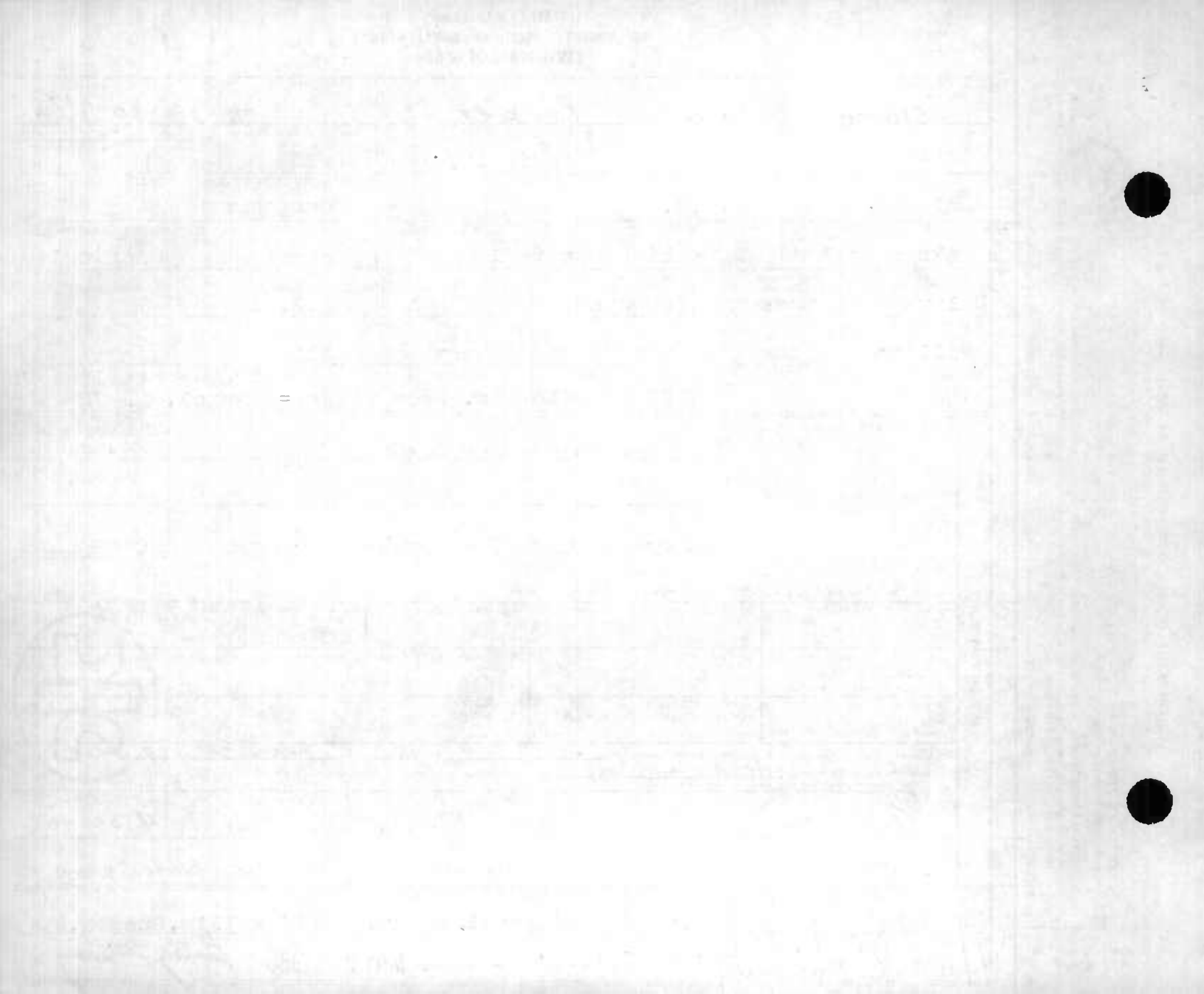
3. The third part of the paper is devoted to a discussion of the application of the theory of the structure of the atom to the problem of the structure of the molecule. It is shown that the structure of the molecule is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are derived from the principles of relativity and the theory of the structure of the atom.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. The certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 0 1 0 1 6 8 | |
|--|--|--|--|---|---|---|--|--|--|---|--|
| 1. FOR
STATE
REGISTRAR | | | | | CERTIFICATE OF DEATH | | | | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT) <u>Clinton William Parker</u> | | | | | 2a. DATE OF DEATH
MONTH <u>4</u> DAY <u>29</u> YEAR <u>80</u> | | | | | 2b. HOUR
<u>7:30</u> A.M. | |
| 3. SEX
<u>Male</u> | | 4. RACE
<u>Cau</u> | | 5. DATE OF BIRTH
MONTH <u>April</u> DAY <u>18</u> YEAR <u>1890</u> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<u>90</u> YRS. | | IF UNDER 1 YEAR
MONTHS <u></u> DAYS <u></u> | | IF UNDER 24 HRS.
HOURS <u></u> MIN. <u></u> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>Delaware</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>Montgomery</u> MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
<u>Takoma Park</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>Adventist Hospital</u> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>Farmer</u> | | 12b. KIND OF BUSINESS OR INDUSTRY
<u>Agriculture</u> | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE <u>Delaware</u> | | 13b. COUNTY <u>Sussex</u> | | 13c. CITY OR TOWN <u>Greenwood</u> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
<u>R.D. 1</u> | | | |
| 14. FATHER'S NAME
FIRST <u>William</u> MIDDLE <u>Thomas</u> LAST <u>Parker</u> | | | | | 15. MOTHER'S MAIDEN NAME
FIRST <u>Mary</u> MIDDLE <u>Alice</u> LAST <u>Wright</u> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) <u>No</u> | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
<u>222 24 0616</u> | | 17. INFORMANT
ADDRESS <u>8909 Montpelier Dr</u>
<u>Dr. Leon Parker = Laurel, MD 20811</u> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>MYOCARDIAL FAILURE</u>
<u>4140</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u></u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>CORONARY ARTERY HEART DISEASE</u>
Years <u></u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>1-2 days</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>CONGESTIVE HEART FAILURE</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<u>P.M.</u> <u></u> <u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>MAY</u> 19 <u>78</u> to <u>APRIL 29</u> 19 <u>80</u> , that (I), (we) lost
saw the deceased alive on <u>APRIL 28</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (If (we) did (did not) view the body after death.) | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Robert B. Irey</u> | | | | | DEGREE
<u>M.D.</u>
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | 22c. DATE SIGNED
<u>4-29-80</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>ROBERT B. IREY</u> | | | | | 22e. ADDRESS
<u>11161 New Hampshire Ave, Silver Spring</u> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<u>Burial</u> | | 23b. DATE
<u>May 2, 1980</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Bridgeville Cem.</u> | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>Bridgeville, Sussex, DE</u> | | | |
| 24. FUNERAL DIRECTOR
NAME <u>Haward E. Hainbury</u> Lic. # <u>1</u> | | 24a. ADDRESS
<u>202 E. 1st St.</u> | | | | 24b. CITY
<u>Bridgeville, DE</u> | | 24c. STATE
<u>DE</u> | | 24d. ZIP CODE
<u>19933</u> | |
| 25a. DATE REC'D. BY REGISTRAR
<u>MAY 2 1980</u> | | | | | 25b. REGISTRAR'S SIGNATURE
<u>Anthony McCreedy</u> | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

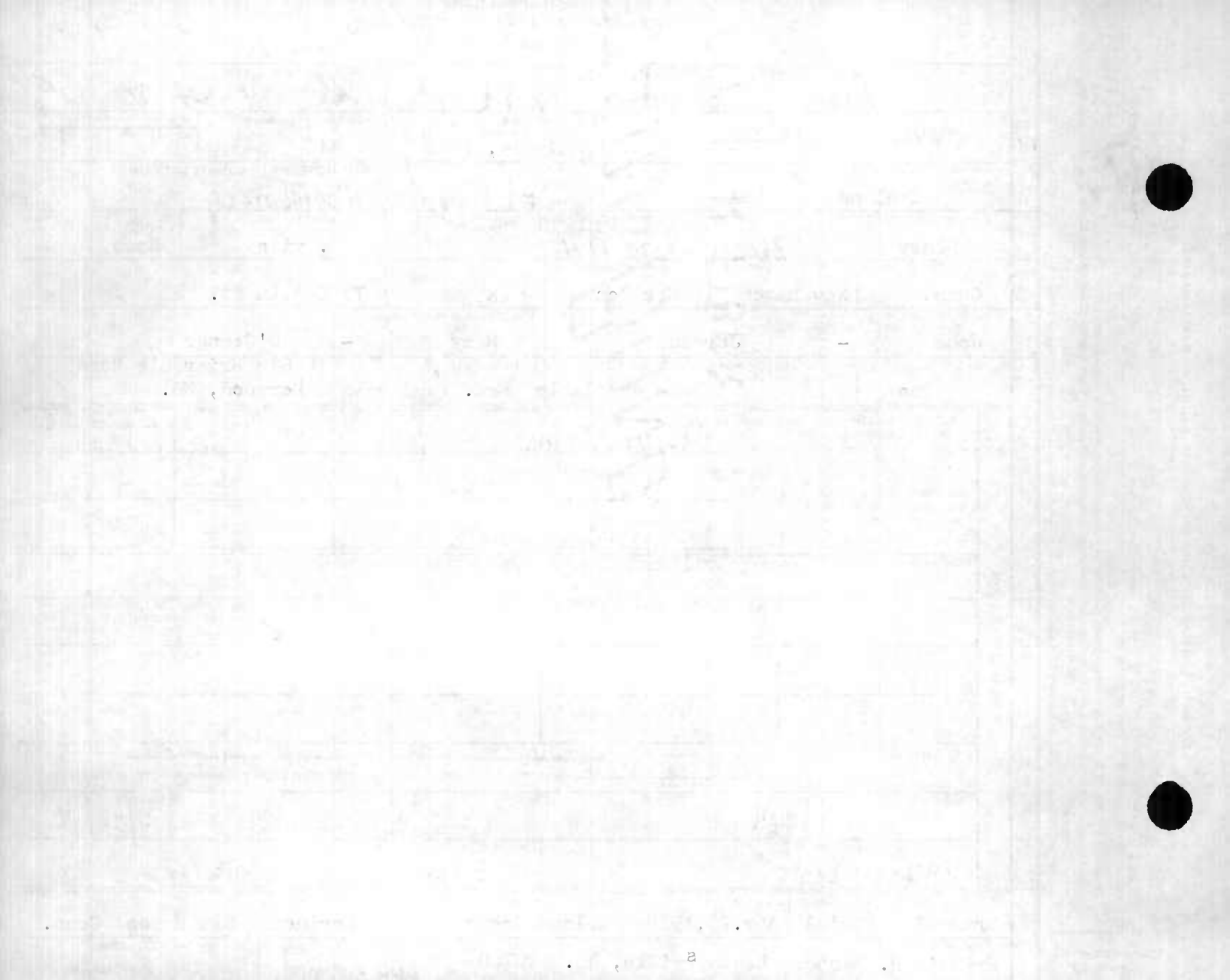
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/76
(VR A 15 (4))

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|-----------------------------------|--|--------------------------------|--|--------------------------------|--|---|--|------------------|--|---|--|------------------------------|--|--|--|--------------------------------------|--|---------------------------|--|--|--|---|--|-----------------------------------|--|
| 1. FOR STATE REGISTRAR | | 2a. DECEASED NAME (TYPE OR PRINT) | | 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. DATE OF DEATH | | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| | | ANNE JORDAN PAYNE | | FEMALE | | WHITE | | July 14, 1898 | | 4 4 24 80 | | Ireland | | USA | | | | Montgomery | | Olney | | Brooke Grove N.H. | | H. wife | | Home | |
| | | Conn. | | New Haven | | Meriden | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 71 Catlin St. | | | | | | | | | | | | | | | | | |
| | | John | | Jordan | | Mary | | O'Connor | | | | | | | | | | | | | | | | | | | |
| | | no | | None available | | Mrs. Paul Goss | | Derwood, Md. | | | | | | | | | | | | | | | | | | | |
| | | 179- | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | |
| | | 179- | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | |
| | | 179- | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | |
| | | 179- | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | |
| | | 179- | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | |
| | | 179- | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | |
| | | 179- | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | |
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| | | 179- | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | |
| | | 179- | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | |
| | | 179- | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | |
| | | 179- | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | |
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



| FOR
1- STATE
REGISTRAR | | | | | | | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|----------------------|--|---|--|---|--|---|--|--|--|---|--|--|--|--|--|--|--|-------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Florence Payne | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 4/1 1980 | | | | | | | | | | 2b. HOUR M | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH
MONTH DAY YEAR Mar. 7, 1896 | | 6. AGE (IN YEARS)
LAST BIRTHDAY 84 YRS. | | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN | | IF UNDER 24 HRS.
MONTHS DAYS HOURS MIN | | 2c. DATE PRONOUNCED DEAD 4/1 1980 | | 2d. HOUR 11:50 a.m. | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va. | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8421 Garland Avenue | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| 13a. STATE Maryland | | | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Silver Spring | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 8421 Garland Avenue | | | | | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST Tom Nickens | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST Frances | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 217-30-0542 | | | | 17. INFORMANT ADDRESS Mary Jones (Daughter) 8221 Garland Ave. Takoma Park, Md. | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial disease
DUE TO, OR AS A CONSEQUENCE OF
(b) generalized arteriosclerosis.
DUE TO, OR AS A CONSEQUENCE OF
(c) 4291
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
None | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION None | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
None | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE John S. Rogers, M.D. | | | | TITLE (SPECIFY) Deputy | | | | MEDICAL EXAMINER | | | | DATE SIGNED 4/1/80 | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D. | | | | ADDRESS 1919 Seminary Road Silver Spring, Montgomery, Md. | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 4-8-80 | | 23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial Cem. | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE Suitland, Dr. Gen. Md. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME George R. Snowden | | | | ADDRESS 246 N. Washington St. Rockville, Md. 20850 | | | | 25a. DATE REC'D. BY REGISTRAR APR 7 1980 | | | | 25b. SIGNATURE | | | | | | | | | |



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

10771

| | | | | | | | | | | | | | | |
|---|---------|------------------|---|---------------|-----------------|--|--|--|---|--|--|---------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE KNOWN OF DEATH | | | MONTH DAY YEAR | | | 2b. HOUR | | |
| Ruth R. Pecca | | | | | | April 16, 1980 | | | 11:00 | | | M | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 1 YR | IF UNDER 24 HRS | 2c. DATE PRONOUNCED DEAD | | | MONTH DAY YEAR | | | 2d. HOUR | | |
| F | W | AUG 19, 1922 | 57 YRS. | | | April 16, 1980 | | | 11:00 | | | M | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| NEW JERSEY | | | U.S.A. | | | | | | Montgomery MD | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| SILVER SPRING | | | 11105 I nwood AVE | | | PHOTOGRAPHIA INDUSTRY | | | | | | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET ADDRESS | | |
| MD | | | Mont. | | | SIL SPR | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 11105 I nwood Ave | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | |
| GEORGE | | | SOPHIA | | | NO | | | 198-18-7513 | | | ARMAND H. PECCA | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | 19. DATE OF OPERATION | | | 20. AUTOPSY? | | | 21a. EXTERNAL CAUSE WAS | | | 21b. TIME OF INJURY | | |
| PART I DEATH WAS CAUSED BY: | | | None | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | HOUR A.M. MONTH DAY YEAR | | |
| 4291 | | | | | | | | | | | | P.M. 19 | | |
| IMMEDIATE CAUSE (a) | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION | | |
| Acute Myocardial Dis | | | | | | WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | | CITY OR TOWN COUNTY STATE | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | |
| None | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | |
| 22b. Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | | | | | | | | | | |
| BURIAL | | | | | | | | | | | | | | |
| 23b. DATE | | | | | | | | | | | | | | |
| 4-19-80 | | | | | | | | | | | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | | | | | | |
| SACRED HEART CEMETERY | | | | | | | | | | | | | | |
| 23d. LOCATION | | | | | | | | | | | | | | |
| MAHANOV CITY PA | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | | | | | | | | | | | |
| FRANCIS J. COLLINS | | | | | | | | | | | | | | |
| 25a. DATE RECEIVED BY REGISTRAR | | | | | | | | | | | | | | |
| APR 22 1980 | | | | | | | | | | | | | | |
| 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | |
| [Signature] | | | | | | | | | | | | | | |

ACTUAL SIGNATURE

EXAMINER'S NAME (TYPE OR PRINT)

JOHN S. ROGERS

TITLE (SPECIFY)

M.D. [Signature]

MEDICAL EXAMINER

DATE SIGNED

April 14, 1980

ADDRESS: 1919 SEMINARY ROAD, SILVER SPRING, MD.

100%

A5152

23

1994

100-31-301

61

201109 1 221458

19803 SMITH, RALPH J. SMITH, MRS. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | 8 0 1 0 / 7 2 | |
|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | 2. DATE OF DEATH | | 3. HOUR | |
| FIRST LAST
Robert L. PHILLIPS Sr. | | MONTH DAY YEAR
April 28 1980 | | 5:26P M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | |
| Male | | Caucasian | | MONTH DAY YEAR
Sept. 19, 1929 | |
| 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 50 YRS. | | Maryland | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| Bethesda | | National Naval Medical Center | | U. S. Army (Retired) Military | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| Maryland | | Anne Arundel | | Glen Burnie | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16. INSIDE CITY LIMITS? | |
| FIRST MIDDLE LAST
John Phillips | | FIRST MIDDLE LAST
Maude Preston | | YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 17b. SOCIAL SECURITY NO | | 17. INFORMANT ADDRESS | |
| Yes | | 1946-1966 213 24 7076 | | Mrs. Herty Phillips See item 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1: DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Pneumonia; adenocarcinoma of rectum
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Apr. 18, 1980, to Apr. 28, 1980, that I (we) lost saw the deceased alive on Apr. 28, 1980, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
D. L. STURTZ, M.D. | | | | 22c. DATE SIGNED
Apr. 29, 1980 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | |
| D. L. STURTZ, M.D. | | | | National Naval Medical Center, Bethesda, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 2 May 80 | | Arlington National | |
| 24. FUNERAL DIRECTOR NAME | | 24b. ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | |
| Singleton Funeral Home, Glen Burnie, Md. | | | | MAY 5 1980 | |
| 25b. REGISTRAR'S SIGNATURE
Ritzy McCreedy | | | | 25c. LOCATION
CITY OR TOWN COUNTY STATE
Arlington Arlington Va. | |

BP

7/25/27

4/10

08/1/11

X

C. n. l. v. c. l. y.

1000 1000 1000

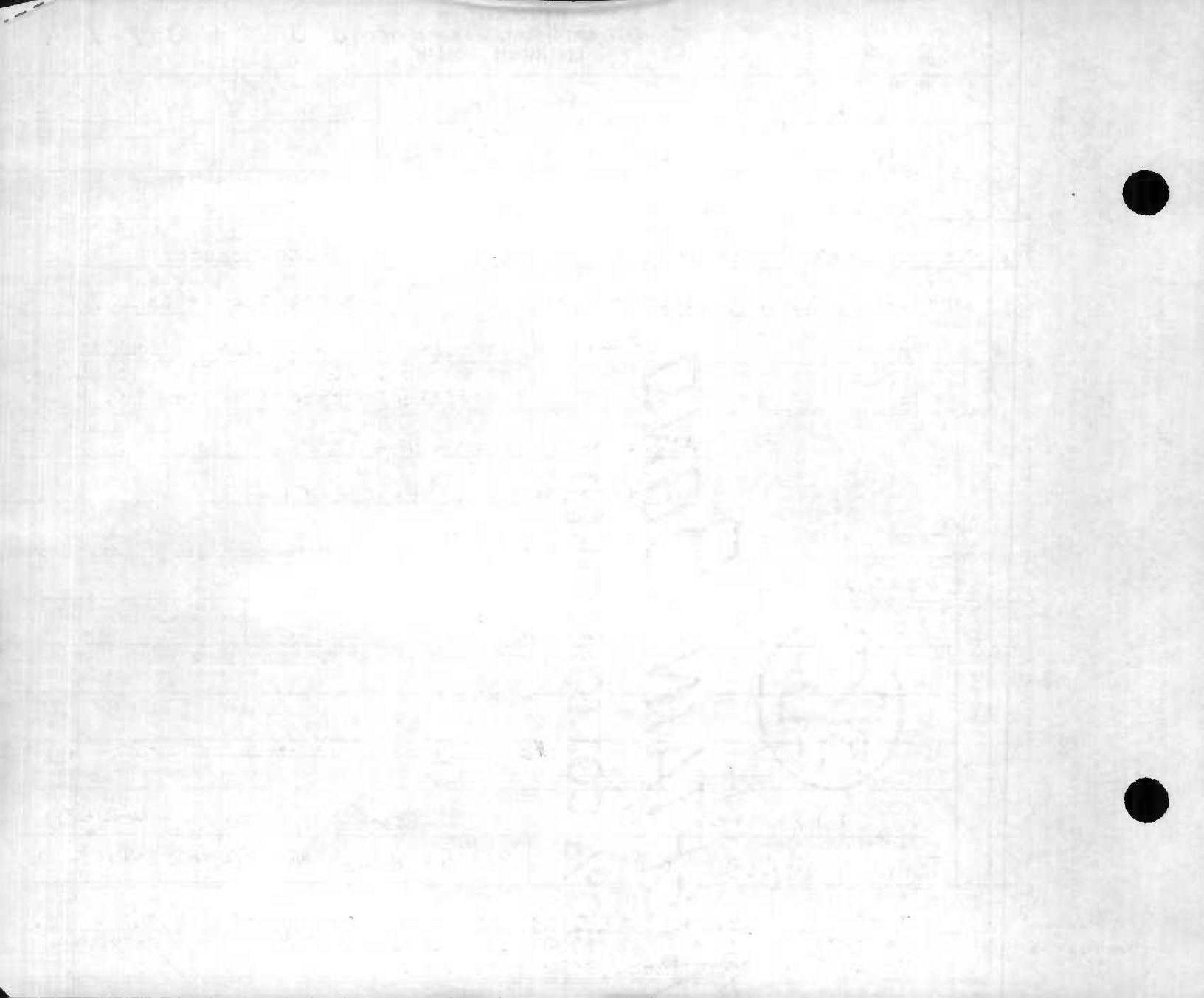
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 1 0 7 7 4
CERTIFICATE OF DEATH

| | | | |
|---|--|--|--|
| 1. FOR
STATE
REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT) Ernest P. Pierce | | 2a. DATE OF DEATH
MONTH DAY YEAR
4 24 80 | |
| 3. SEX
male | | 4. RACE
White | |
| 5. DATE OF BIRTH
MONTH DAY YEAR
3 6 1898 | | 6. AGE (IN YEARS LAST BIRTHDAY)
82 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Bldg. Contractor Building | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | 13b. COUNTY
Mont. | |
| 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS
14804 Claude Lane | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Greer Pierce | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Minnie Josephine Conklin | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
579-07-2163 | |
| 17. INFORMANT
Mrs. C. | | ADDRESS
5369 Brook Way | |
| | | B Neville Dorrycott Columbia, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ASPIRATION PNEUMONIA
3352
DUE TO, OR AS A CONSEQUENCE OF
(b) RESPIRATORY INEFFICIENCY
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) BULBAR PALSY
DUE TO, OR AS A CONSEQUENCE OF
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
CARDIAC STANDSTILL | | | |
| 19a. DATE OF OPERATION
4-22-80 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
PHARYNGOSCOPY FOR TUBE ALIMENTATION | |
| 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (a) this hospital attended the deceased from 4-13 19 80 to 4-24 19 80 that (b) we last saw the deceased alive on 4-24 19 80 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (b) we (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
John B. Nason, MD | | 22c. DATE SIGNED
4-24-80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JOHN B. NASON, MD | | 22e. ADDRESS
800 PERSHING DR. SILVER SPRING, MD | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Apr. 28, '80 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood P.G. Md. | |
| 24. FUNERAL DIRECTOR
NAME
Hines/Rinaldi | | 25a. ADDRESS
11800 N. Hamp. Ave., Silver Spg. MD. | |
| 25b. REGISTRATION NO.
APR 28 1980 | | 25c. REGISTRAR'S SIGNATURE
[Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|
| 1- STATE REGISTRAR | | | | | | | | | | | |
| 2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 04-13 1980 8:13p | | | | | | | | | | | |
| 7b. HOUR | | | | | | | | | | | |
| 1. DECEASED NAME FIRST MIDDLE LAST ARNOLD C. POLLOCK | | | | | | | | | | | |
| 3. SEX MALE 4. RACE WHITE 5. DATE OF BIRTH MONTH DAY YEAR 07 -05 -35 6. AGE (IN YEARS LAST BIRTHDAY) 44 YRS. IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | | | | | | | | | |
| 7c. DATE PRONOUNCED DEAD 04-13 1980 8:13p | | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C. 7b. CITIZEN OF WHAT COUNTRY? USA 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD. | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH SILVER SPRING 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL OF S.S. 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner/Opntr 12b. KIND OF BUSINESS OR INDUSTRY Food Carryout | | | | | | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Montgomery 13c. CITY OR TOWN Silver Spring 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 14908 Claude Lane | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JEROME POLLOCK 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IDA LEWIS | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES unknown 16b. SOCIAL SECURITY NO. 579-46-1988 17. INFORMANT ADDRESS Gayle Pollock 14908 Claude La., S.S., Md. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY: 4149 IMMEDIATE CAUSE (a) Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Richard L. Whelton M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED April 13, 1980 | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) RICHARD L. WHELTON ADDRESS 7100 Balboa Blvd | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 4-16-80 23c. NAME OF CEMETERY OR CREMATORY National Memorial Park 23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church, Virginia | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels; 1170 Rockville Pike ADDRESS Rockville, Md. 25a. DATE REC'D. BY REGISTRAR APR 17 1980 25b. REGISTRAR'S SIGNATURE Patricia McCready | | | | | | | | | | | |

10-11-40
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10-11-40

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201
Released by Dr. Eugene ME on 4/28/80
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and it may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|-----------------------------|--|
| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 0 1 0 7 7 6 | |
| 1. FOR STATE REGISTRAR Anna Poloway | | | | | | | | | | REG. NO. | |
| 1 DECEASED NAME (TYPE OR PRINT) ANNA | | | | FIRST MIDDLE LAST POLOWAY | | | | 2a DATE OF DEATH MONTH DAY YEAR 4 28 80 | | 2b HOUR 6 PM | |
| 3 SEX F | | 4 RACE CAU | | 5 DATE OF BIRTH MONTH DAY YEAR March 14, 1895 | | 6 AGE (IN YEARS LAST BIRTHDAY) 85 YRS | | 7 IF UNDER 1 YEAR MONTHS DAYS | | 8 IF UNDER 24 HRS HOURS MIN | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH MONT MD | | | | | |
| 10 CITY OR TOWN OF DEATH Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS Hosp | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Seamstress | | 12b KIND OF BUSINESS OR INDUSTRY Dress Factory | | | |
| 13a STATE Md. | | 13b COUNTY Montgomery | | 13c CITY OR TOWN Rockville | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS 6121 Montrose Rd. | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Isaac Poloway | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b SOCIAL SECURITY NO. None | | 214-22-6612 | | 17 INFORMANT Joseph Paull Nephew | | ADDRESS Wash.D.C. 20016 4827 Nebraska Ave N.W. | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1: DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute SEPTICEMIA & RESPIRATORY ARREST</u>
<u>5601</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>INTESTINAL ILEUS</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 DAYS</u> | | | | | | | | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Acute Renal Failure</u> | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a I certify that (1) (this hospital) attended the deceased from <u>4/25</u> , 19 <u>80</u> , to <u>4/28</u> , 19 <u>80</u> , that (2) (we) last saw the deceased alive on <u>4/28</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did not) view the body after death. | | | | | | | | | | | |
| 22b SIGNATURE Robert L. Rosenberg | | | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c DATE SIGNED 4/28/80 | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT L. ROSENBERG, MD | | | | 22e ADDRESS 6121 MONTROSE RD, ROCKVILLE, MD 20852 | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b DATE 4-30-80 | | 23c NAME OF CEMETERY OR CREMATORY Lee's Crematory | | 23d LOCATION CITY OR TOWN COUNTY STATE Washington, D.C. 20002 | | | | | |
| 24. FUNERAL DIRECTOR Lee Funeral Home 300-4th St. N.E. Wash.D.C. 20002 | | | | 25a. DATE REC'D. BY REGISTRAR MAY 1 1980 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | |



| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 10777 | |
|--|--|--|--|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | 2a. DATE OF DEATH KNOWN <input checked="" type="checkbox"/> MONTH DAY YEAR 4 2 80 | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DR. Michael S. Popkin | | | | | | | | | | 2b. HOUR 12:15 A.M. | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 6 1 10 | | 6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS. | | 7. IF UNDER 1 YR. MONTHS DAYS | | 7c. DATE PRONOUNCED DEAD 4 2 80 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) AUSTRIA | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | 10. CITY OR TOWN OF DEATH D.C. Spg. | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp. | |
| 12a. USUAL RESIDENCE (IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland | | 13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13b. CITY OF RESIDENCE Montgomery | | 13c. STREET Silver Spring | | 13d. CITY OF RESIDENCE 1131 University Blvd., West | | 13e. STATE OF RESIDENCE | |
| 14. FATHER'S NAME FIRST MIDDLE LAST CHARLES POPKIN | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FANNY SHERMAN | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. WW 11 | |
| 17. INFORMANT ADDRESS BETTY POPKIN, same as #13 | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 1 DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) 4291 Acute Myocardial Dis. | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Myocardial Dis. | | | | | | | | | | Vrs. | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) None | | | | | | | | | | | |
| 19a. DATE OF OPERATION None | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE John S. Rogers | | | | TITLE (SPECIFY) M.D. Dep. | | | | DATE SIGNED April 2, 1980 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) JOHN S. ROGERS, MD | | | | ADDRESS 1919 SEMINARY ROAD, SILVER SPRING, MARYLAND | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE 4/4/1980 | | | | 23c. NAME OF CEMETERY OR CREMATORY JUDEAN MEMORIAL GARDENS | | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE OLNEY, MONTGOMERY, MARYLAND | | | | 24. DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME | | | | 25a. DATE REC'D. BY REGISTRAR APR 7 1980 | | | |
| 23e. ADDRESS 232 CARROLL STREET, N. W., WASHINGTON, D. C. | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | | | |



[Faint, mostly illegible text and markings covering the central portion of the page, possibly bleed-through from the reverse side.]

[Faint text at the bottom of the page, including what appears to be a signature and some printed information.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 0 1 0 7 7 8 | |
|--|--|--|--|---|--|---|--|---|--|---|--|
| 1- FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | | MONTH DAY YEAR | | 2b. HOUR | |
| David Porter | | | | 4 23 80 | | | | 140 P M | | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | 7 IF UNDER 1 YEAR | | 7 IF UNDER 24 HRS | |
| Male | | Caucasian | | Feb. 11, 1883 | | 97 YRS | | MONTHS DAYS | | HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Scotland | | U.S.A. | | | | Montgomery MD. | | | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| Bethesda | | Suburban Hospital | | | | Builder | | Construction | | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13b COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| Maryland | | | | Montgomery | | Bethesda | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 7102 Amy Lane | |
| 14 FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| Robert Porter | | | | Jane Grant | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT ADDRESS | | | | | |
| No | | | | 131-03-8616 | | Robert Porter, Same as #13 | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) Congestive Heart Failure | | | | | | | | | | 2 days | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease | | | | | | | | | | 25 yrs | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| | | | | P.M. 19 | | | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET | | CITY OR TOWN | | COUNTY STATE | |
| | | | | | | | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from Oct 1965, to 4-23-80, that (I) (we) last saw the deceased alive on 4-23-80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b SIGNATURE | | | | DEGREE | | | | 22c DATE SIGNED | | | |
| Stephen W. Dejeu, M.D. | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 4-23-80 | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e ADDRESS | | | | | | | |
| STEPHEN W. DEJEU, M.D. | | | | 6719 WILSON LANE, BETHESDA, MD 20834 | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION CITY OR TOWN COUNTY STATE | | | |
| Cremation | | | | 4/25/80 | | Metropolitan Crem. | | Alexandria, Virginia | | | |
| 24 FUNERAL DIRECTOR NAME | | | | | | 24b DATE REC'D BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | | | |
| Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland | | | | | | APR 29 1980 | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, IT MUST BE FILED IN THE FILES OF THE MEDICAL EXAMINER. PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR'S COPY OF THIS CERTIFICATE SHOULD BE FILED IN THE FILES OF THE MEDICAL EXAMINER. GIVE PAGE NO. 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS.

FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESIDENT STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP_____

DHMH - 17
(VR A15 ME (5))
30M 7/73

Item #1 per phone call
FOR
1- STATE w/Fun. Home 5/12/80
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|-------------------------|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
R Roy | | FIRST
Lee | | MIDDLE
Porter | | LAST | | 20. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
4 30 19 80 | | 21. HOUR
6:45 A | |
| 3. SEX
Male | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
March 7, 1949 | 6. AGE (IN YEARS)
(EAST BIRTHDAY)
31 YRS. | 7. IF UNDER 1 YR.
MONTHS DAYS
4 30 | 8. IF UNDER 24 HRS.
HOURS MIN
19 80 | 2c. DATE PRONOUNCED DEAD
4 30 19 80 | | 2d. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | | 2e. HOUR
6:45 A | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
North Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | | 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Rt. 495 | |
| 12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
N. Carolina | | 13b. COUNTY
Hertford | | 13c. CITY OR TOWN
Winton | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
Factory Street | | 12b. KIND OF BUSINESS OR INDUSTRY
Trucking | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Jarvis Porter | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Dorothy Kearney | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
242-78-8190 | | 17. INFORMANT
Betty Lou Porter same as #13 | | ADDRESS | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Asphyxia
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) Compression of chest
DUE TO, OR AS A CONSEQUENCE OF
(c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
6:30 AM 4 30 19 80 | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
6:30 AM 4 30 19 80 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
driver of tractor-trailer lost control | | 21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
street | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
Rt. 495 Bethesda, Mont. Md. | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | 22b. TITLE (SPECIFY)
Deputy Chief | | 22c. MEDICAL EXAMINER
Thomas D. Smith, M.D. | | 22d. DATE SIGNED
4/30/80 | | 22e. EXAMINER'S NAME (TYPE OR PRINT)
Thomas D. Smith, M.D. | | 22f. ADDRESS
111 Penn St. Balto., MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
5-4-80 | | 23c. NAME OF CEMETERY OR CREMATORY
Jordan Grove Cemetery Winton, Hertford N.C. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Winton, Hertford N.C. | | 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey Funeral Homes P.A., Bethesda, Maryland | | 25. DATE RECEIVED BY REGISTRAR
MAY 8 1980 | |

March 7, 1951

Mr. J. Edgar Hoover

Director, Federal Bureau of Investigation

Washington, D. C.

Dear Mr. Hoover:

Enclosed

is

one

copy of a letterhead memorandum dated and captioned as above.

The letterhead memorandum is being submitted to you for your information and for your review and comment. It is being submitted to you in accordance with the provisions of the Executive Order of March 1, 1950, which requires that all lettershead memoranda be submitted to the Director for his review and comment before they are forwarded to the President or other high officials of the Government.

I am, Sir, very respectfully,
Your obedient servant,
[Signature]

Very truly yours,
[Signature]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE ADVISE THE CHIEF OF POLICE. **PENDING**: IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF OF POLICE. GIVE PAGE 5 TO THE CHIEF OF HEALTH. GIVE PAGE 6 TO THE CHIEF OF VITAL RECORDS. GIVE PAGE 7 TO THE CHIEF OF THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE. DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | REG. NO. 8010780 | |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
FIRST MIDDLE LAST
Clara E. Potter | | | | | | 2a. DATE KNOWN OF DEATH
<input checked="" type="checkbox"/> MONTH DAY YEAR
<input type="checkbox"/> ESTIMATED 4-1-1980 | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 27 1898 | | 6. AGE (IN YEARS LAST BIRTHDAY)
MONTHS DAYS HOURS MIN.
81 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Mass. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Secretary | |
| 13a. STATE
D.C. | | 13b. COUNTY
Washington | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
4210 Jennifer St., N.W. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Otto F. Ehrlich | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lura M. Ruediger | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | | 16b. SOCIAL SECURITY NO.
Unknown | | 17. INFORMANT
ADDRESS
Thomas F Potter, Son, same as item 13. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Heart Failure.
DUE TO, OR AS A CONSEQUENCE OF
(b) Hypertensive Cardio-Vascular Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____ | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
_____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19____ | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from:
Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE John G Ball | | | | TITLE (SPECIFY)
M.D. Deputy | | DATE SIGNED April 1, 1980 | |
| EXAMINER'S NAME (TYPE OR PRINT) John G Ball, M.D. | | | | ADDRESS 7936 1st Georgetown Rd., Bethesda, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
4/7/1980 | | 23c. NAME OF CEMETERY OR CREMATORY
ARLINGTON NATIONAL CEM | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ARLINGTON, VIRGINIA | |
| 24. FUNERAL DIRECTOR
NAME Joseph Gawler's Sons Inc.
ADDRESS 5130 Wisconsin Ave., N.W. Wash., D.C. | | | | 25a. DATE REC'D. BY REGISTRAR
APR 8 1980 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

no

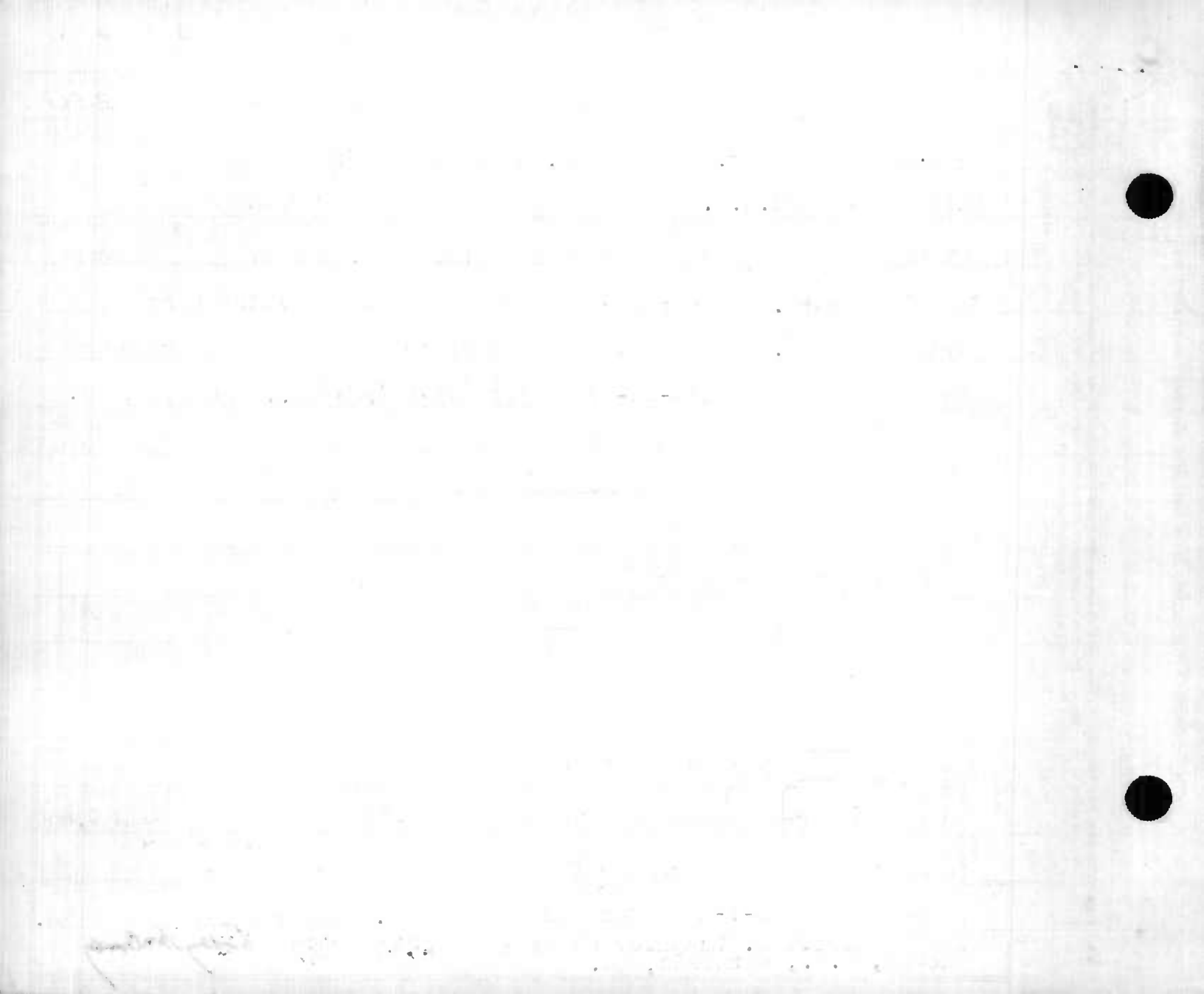
2022-2023

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|---|---|---|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) <i>Isabelle D Bowers</i> | | | | | 2a. DATE OF DEATH MONTH <i>4</i> DAY <i>2</i> YEAR <i>80</i> | | | 2b. HOUR <i>3:50 P.M.</i> | |
| 3 SEX <i>Female</i> | | 4 RACE <i>Cauc.</i> | | 5 DATE OF BIRTH MONTH <i>Nov.</i> DAY <i>30</i> YEAR <i>1902</i> | | 6 AGE (IN YEARS (LAST BIRTHDAY)) <i>77</i> YRS. | | 7. IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i> IF UNDER 24 HRS. HOURS <i></i> MIN <i></i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Ohio</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD. | | | |
| 10 CITY OR TOWN OF DEATH <i>Bethesda</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Suburban Hospital</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i> | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <i>MD</i> 13c. COUNTY <i>Montg.</i> 13d. CITY OR TOWN <i>Bethesda</i> | | | | | 13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13f. STREET ADDRESS <i>5908 Carlton Lane</i> | | |
| 14 FATHER'S NAME FIRST <i>Charles</i> MIDDLE <i>M.</i> LAST <i>Noble</i> | | | | | 15 MOTHER'S MAIDEN NAME FIRST <i>Margarita</i> MIDDLE <i></i> LAST <i>McCannon</i> | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i> | | | | | 16b. SOCIAL SECURITY NO <i>218-24-0796</i> | | 17 INFORMANT ADDRESS <i>Katherine Mergner 8517 Beech Tree Rd., Bethesda, Md.</i> | | |
| 11 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> | |
| 410-
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Atherosclerotic Cardiovascular Disease</i> | | | | | | | | - | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i></i> | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Respiratory arrest</i> | | | | | | | | | |
| 19a. DATE OF OPERATION <i>-</i> | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>-</i> | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR <i>A.M.</i> MONTH <i></i> DAY <i>19</i> YEAR <i></i> | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET <i></i> CITY OR TOWN <i></i> COUNTY <i></i> STATE <i></i> | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>March 31</i> , 19 <i>80</i> , to <i>April 2</i> , 19 <i>80</i> , that (I) (was) last saw the deceased alive on <i>April 2</i> , 19 <i>80</i> , and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>Augustus A. Aquino M.D.</i> | | | | | DEGREE <i>M.D.</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED <i>April 2, 1980</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Augustus A. Aquino, M.D.</i> | | | | | 22e. ADDRESS <i>10401 Old Georgetown Road Bethesda, Md. 20014</i> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i> | | | 23b. DATE <i>3-7-80</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven Cem.</i> | | 23d. LOCATION CITY OR TOWN <i>Silver Spring</i> COUNTY <i></i> STATE <i>Md.</i> | | |
| 24 FUNERAL DIRECTOR NAME <i>Robert A. Pumphrey</i> | | | | | 25. DATE REC'D. BY REGISTRAR <i>APR 9 1980</i> | | | | |
| Homes, P.A., Bethesda, Md. | | | | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certification completed.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8010782 | |
|---|--|---|--|--|---|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FREDERICK CHARLES PRIEBE | | | | | 2a. DATE OF DEATH MONTH 4 DAY 2 YEAR 80 | | | 2b. HOUR 2:15 AM | | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH JULY DAY 2 YEAR 1898 | | 6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 7. IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO. MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Motorman | | 12b. KIND OF BUSINESS OR INDUSTRY Street Car | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Mont. | | 13c. CITY OR TOWN Rockville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 10731 Hunting Lane | | | |
| 14. FATHER'S NAME FIRST Herman MIDDLE C. LAST Priebe | | | | | 15. MOTHER'S MAIDEN NAME FIRST Bertha MIDDLE - LAST Feiblekorn | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 578-10-6417 | | 17. INFORMANT ADDRESS Edna L. Hunt Same as # 13 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cardiac arrest | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 4140
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) congestive heart failure | | | | | | | | | | 1 yr. | |
| (c) arteriosclerotic heart disease | | | | | | | | | | 5 yrs. | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Bronchopneumonia | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 4, 1974 to April 19, 1980 , that (I) (we) last saw the deceased alive on 4/11/80 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Marvin Wadler DEGREE M.D. | | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 4/12/80 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARVIN WADLER | | | | | | 22e. ADDRESS 8218 WISCONSIN AV. BETH, MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Apr. 4, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel | | 23d. LOCATION CITY OR TOWN Sunshine COUNTY Mont. STATE Md. | | | | | |
| 24. FUNERAL DIRECTOR FRANCIS H. BARBER LAYTONSVILLE, MD. 20760 | | | | | | 25a. DATE REC'D. BY REGISTRAR APR 7 1980 | | 25b. REGISTRAR'S SIGNATURE Anthony Kelly | | | |

APR 3 1980